



1760 COUNTY ROAD J WAHOO, NE 68066
402.443.4191 402.443.1427
WWW.SAUNDERSMEDICALCENTER.COM

SPORTS PHYSICAL CONSENT FORM

Student Name _____

Address _____

Date of Birth _____ Social Security Number _____

Phone Number _____ School _____

The above student has my consent to receive a sports physical, as required by his/her school, from Saunders Medical Center.



Our HIPAA Notice of Privacy Practices is available on our web site at www.saundersmedicalcenter.com; it is also available at the Saunders Medical Center Clinic. If you would like a copy, please check the box below and a notice will be mailed to you. Your signature confirms that you have been given an opportunity to review our Notice of Privacy Practices.

Yes, Please mail the Notice of Privacy Practices to the above address.

Parent or Guardian of Student (Please Print) _____

Signature of Parent or Guardian _____

Date _____