



Athlete Registration

Name _____ Date of Birth _____
Street Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Email _____

Name of school _____ Grade _____
Sport _____ Position _____ Coach _____
Sport _____ Position _____ Coach _____
Sport _____ Position _____ Coach _____

Personal Goals _____

Primary Care Physician: _____ Phone _____

Emergency Contact _____ Relationship _____
Home Phone _____ Cell Phone _____

Responsible Party:

Name _____
Address (if different) _____
Phone _____ Relationship to you _____

I am responsible for and agree to the payment of all fees for services provided.

I the undersigned consent to and authorize treatment which may be considered advisable by the physical therapist / athletic trainer or their designates. I acknowledge no guarantees have been made as to the results of treatment. I will consult my practitioner with any questions or concerns immediately.

Signature _____ Parent/Guardian (if under 18) _____

Date _____

830 Distribution Drive, Beavercreek, Ohio 45434 Phone 431-0300 Fax 431-9100