



ECRMC Rehabilitation Dept.  
Phone: (760) 370-3761  
7-9 am Saturday or Sunday

### Parent Consent Form

Athlete's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

High School: \_\_\_\_\_ Injury: \_\_\_\_\_

I hereby give my consent for my son/daughter \_\_\_\_\_ to be seen and evaluated by the Sports Medicine Physicians and Staff (Orthopedic Surgeon, Family Practitioner, Certified Athletic Trainers and Physical Therapists) at the El Centro Regional Sports Injury Clinic. I authorize the Sports Medicine Physicians and Staff to share information regarding my son/daughter's injury noted above with the athletic training and coaching staff at their school.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_ Contact number \_\_\_\_\_

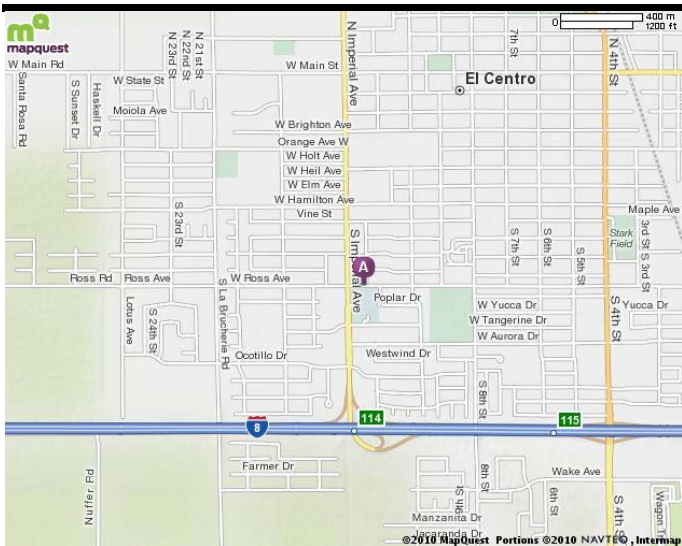
### Referring Medical Professional

Mechanism of Injury: \_\_\_\_\_

Working Dx: \_\_\_\_\_

Medical Professional / Athletic Trainer name: \_\_\_\_\_

Contact number: \_\_\_\_\_



From East or West:  
Interstate 8 Exit Imperial Avenue  
Turn Right on Ross Avenue and make an immediate right into parking lot.

From North:  
Highway 86 South towards city of El Centro  
Travel one mile past Main Street (El Centro) and turn left on Ross Avenue  
Make an immediate right into parking lot

From South:  
Travel North on Highway 111 to Interstate 8 West  
Travel 4 miles and exit Imperial Avenue  
Turn right on Ross Avenue and make an immediate right into parking lot.