

Georgia Soccer Refusal to Permit Medical Treatment

PLAYER'S NAME _____ AGE _____

I have been advised and it has been recommended by the Ga. licensed health care provider/physician _____ [Print Name] _____ [Title] that the minor child for whom I am the legal guardian, undergo the following test(s), treatment(s), or procedure(s):

The Ga. licensed health care provider/physician has satisfactorily explained the above recommended test(s), treatment(s), or procedure(s) to me, the risks and benefits of this recommendation, the alternatives to this recommendation and the probable consequences of not receiving the test(s), treatment(s), or procedure(s). In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

Notwithstanding the recommendation of the Ga. licensed health care provider/physician and with the knowledge I have regarding this recommendation, I have decided **NOT** to accept/permit the test(s), treatment(s), or procedure(s) listed above. I understand that my failure to follow the Ga. licensed health care provider's/physician's advice may seriously affect the health of the person under my guardianship.

By signing below, I assume responsibility for all the risks and consequences of my refusal. I also release

[HCP Name] _____ [Title] _____ and other persons participating in the care of the minor child under my guardianship from all responsibility for any unfavorable or bad results that may occur as a result of my refusal to accept/permit the proposed recommendation.

Parent/Guardian [Print Name] _____ Date _____ Time _____

Parent/Guardian [Signature] _____

Club Official/Coach [Print Name] _____ Date _____ Time _____

Club Official/Coach [Signature] _____

Ga. licensed health care provider [Print Name] _____ Date _____

Health care provider title _____ Ga. license Number _____ Exp. Date _____

Contact Address: _____

Contact Phone: Cell: _____ Office: _____

Witness Name [Print] _____ Contact Phone _____