Required for all Varsity Athletes

DAVIDSON COLLEGE SPORTS MEDICINE

Name (print) _____
Last First

Date of Birth _____/_____/_____
Month Day Year

Anticipated Graduation Year _____ Student ID _____

Sport _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize the Center for Student Health & Well-Being to release information contained in my new student Health and Immunization records, including sickle cell testing documentation, to the Davidson College Sports Medicine staff for the purpose of advising and eligibility for varsity team sports.

Student Signature_____

Date _____/_____/_____