



Repair | Rehabilitate | Rejuvenate

Physiotherapy, Exercise Physiology
& Remedial Massage

FIZZIO FOR LIFE AND MARSDEN STATE HIGH SCHOOL HEALTH PARTNERSHIP CONSENT FORM

Student Name: _____

Date of Birth: _____

Excellence Program: _____

Coach: _____

Parent/Guardian details (if under 18) _____

Address: _____

Postcode: _____

Email:* _____ Mobile: _____

I _____ give consent for the assessment of my child _____
by an Allied Health Professional from Fizzio for Life at Marsden High School.

I understand that:

- The assessments at the school are provided free of charge.
Any ongoing treatment through Fizzio for Life is a fee based service.
- The assessment is conducted in the presence of the school nurse or another adult
- The information provided at the assessment is of a general nature, is not to be construed as a diagnosis, and that further medical advice or treatment may be required and recommended by the therapist.
- THIS CONSENT FORM WILL REMAIN VALID FOR 2018 UNLESS OTHERWISE ADVISED IN WRITING.

I give permission for:

- a representative of Fizzio for Life to provide first aid or first response care should my son or daughter be injured in a school sports or dance event.
- information from their care or assessment to be released to their coach, and HOD.
- to be included in the mailing list of Fizzio for Life.

I WOULD / WOULD NOT like to know more about direct debit or package options for my son or daughter.

Signed: _____

Name: _____ (PARENT/GUARDIAN)

**STUDENTS WITHOUT A CONSENT FORM SIGNED BY A
PARENT/GUARDIAN WILL NOT BE ASSESSED OR REVIEWED
UNDER ANY CIRCUMSTANCES.**



MEDICAL DETAILS OF STUDENT

GP Name: _____

GP Address: _____

Any previous illnesses or injuries?: _____

What area was injured? _____

- | | | | | |
|--------------------------------|--------------------------------|--------------------------------|-------------------------------|-----------------------------------|
| <input type="checkbox"/> Foot | <input type="checkbox"/> Ankle | <input type="checkbox"/> Knee | <input type="checkbox"/> Hip | <input type="checkbox"/> Shoulder |
| <input type="checkbox"/> Wrist | <input type="checkbox"/> Hand | <input type="checkbox"/> Elbow | <input type="checkbox"/> Back | <input type="checkbox"/> Neck |

Other _____

Do you have ongoing pain or weakness in this area? NO / YES - PAIN YES - WEAKNESS

GENERAL HEALTH

What aspect of your training or sport do you feel you need help with?

- | | | |
|--|---|--|
| <input type="checkbox"/> Nutrition | <input type="checkbox"/> Taping | <input type="checkbox"/> Injury Management |
| <input type="checkbox"/> Strength and Conditioning | <input type="checkbox"/> Rehabilitation | <input type="checkbox"/> Other _____ |