ALLIED
Physical Therapy
WELLNESS COMMUNITY™

Cape Coral, FL • (239) 242-0070

Athlete Information Form

Athlete Information

Last Name _____ First Name _____ MI _____

Address _____

Address2 _____ City _____ State _____ ZIP _____

Home Phone _____ Cell Phone _____

Date of Birth _____ Gender _____ Age ____ Email _____

Team _____ Coach _____ Position_____

Parent or Legal Guardian

Last Name _____ First Name _____

Relationship _____ Phone _____ Email _____

Primary Care Physician

Name _____ Phone _____

Address _____ City _____ State _____ ZIP _____

Allergies / Medical History

_____

_____

Consent for Treatment

I do hereby consent to such treatment by the authorized licensed personnel of Allied Physical Therapy as may be dictated by prudent medical practice by my child's injury.

_____

Signature of Parent or Guardian

_____ _____

Print Name Date

IMPORTANT

When you have completed and signed this form, please return it either to Dr. Harkness or to your coach.