

BUCKNELL UNIVERSITY
SPORTS MEDICINE CENTER
MEDICAL RELEASE WAIVER



Sport _____ Class of _____ SS# _____ - _____ - _____ Birthdate ____/____/____
Name _____ Sex: Male Female
(Last) (First) (M.I.)

I, _____, hereby acknowledge and consent for the athletic training and medical professionals associated with Bucknell University to disclose my medical records/information. I give authorization to _____ to release all information regarding my medical history, record of injury and treatment, surgery, and rehabilitation in reference to the following injury _____ which occurred on _____.

Student-Athlete's Signature

Date