



Pulaski Memorial Hospital
Medical and Surgical Group
540 Hospital Drive
Winamac, IN 46996
Phone: 574.946.2194

Sports Physical Consent

Patient Name: _____

Patient Date of Birth: _____

Patient Address: _____ City: _____

State: _____ ZIP: _____ Home Phone: _____

Parent Name: _____

Emergency Phone Number: _____

I, _____ authorize the physicians, their
Parent Name

associates and employees of Pulaski Memorial Hospital Medical & Surgical Group

to perform a sports physical exam on _____
Child's Name

Parent
Signature: _____

Date: _____