



ATHLETE WAIVER OF MEDICAL EVALUATION FOR HEARING AIDS

To Whom It May Concern:

I know that the Food and Drug Administration (FDA) has determined that it is in my best health interest if I undergo a hearing evaluation by a licensed physician (preferably a physician who specializes in diseases of the ear) before receiving a hearing aid(s). I am over 18 and wish to decline a medical evaluation by a licensed physician before receiving a hearing aid(s). I understand that I may rescind this waiver at the time of the Healthy Hearing screening.

TO BE COMPLETED BY THE ATHLETE

Athlete Name:

Athlete DOB:

ATHLETE SIGNATURE (Required for an adult athlete with capacity to sign legal documents)

I have read and understand this form. If I have questions, I will ask them. By signing below, I agree to the terms and conditions of this form.

ATHLETE SIGNATURE:

Date:

PARENT/LEGAL GUARDIAN SIGNATURE (Required for an athlete who lacks capacity to sign legal documents or is under 18)

I am a parent or legal guardian of the athlete named above. I have read and understand this form and have explained the contents of the form to the athlete. If I have questions, I will ask them. By signing, I agree to the terms and conditions of this form on my own behalf and on behalf of the Athlete.

PARENT/LEGAL GUARDIAN SIGNATURE:

Date:

Parent/Legal Guardian Name:

Relationship: