

CONSENT TO PARTICIPATE

Name: _____ D.O.B: _____ Phone/Email: _____

Address: _____

Thank you for volunteering to participate in the University of Florida Doctor of Physical Therapy (DPT) Program education clinical and health promotion activities. I agree to participate in the UF DPT program clinical or community activities **and understand and agree that:**

- I am participating voluntarily without compensation or travel costs.
- Students will be: 1) collecting information about my health conditions, complaints, function and goals, 2) performing examinations, 3) developing treatment plans or 4) health and wellness plans.
- Any information gathered will only for the purposes of providing recommendations for my benefit or for learning purposes for the Physical Therapy students participating in the class. Activities may be in person or using virtual communication.
- The student(s) will be presenting information related to my health to other students and faculty for learning purposes.
- The length of treatment varies, dependent on the class schedule, and may not address all my health needs.
- If I am concerned about the tasks I am instructed to perform or am concerned for my health, I will report signs of difficulty immediately to allow assessment, treatment or exercise to be modified and that I may discontinue participation at any time. I understand and agree that I am responsible for obtaining my own health care services from a health care provider of my choice if recommended by the supervising clinician.
- I further understand and agree I am participating in a learning experiences for the student(s), and that s/he is NOT a physical therapist. I understand that the student(s) will be supervised by faculty. I agree that students will not be asked to provide services or recommendations outside of class activities or without supervision

By checking the box(es), I authorize :

Storage of my contact information to be contacted for future opportunities

Storage and use of my photographs, videos for educational purposes

Use of my information without identifying information for case studies for educational purposes

I personally assume all risks in connection with my participation and I further release the University of Florida Board of Trustees, Department of Physical Therapy, faculty and students from all claims, suits, costs, losses, compensation and expenses of any nature arising from any injury, or other risk related to or caused by my participation in these learning activities or community health events.

I sign this consent willingly and voluntarily, and agree that this consent is valid from the date of the initial visit and expires upon the termination of the program. I may withdraw my consent at any time by writing to the University of Florida, Department of Physical Therapy program.

(Signature)

(Printed Name/s Volunteer/Guardian)

(Date)

(Name of Child/if applicable: _____)