Please use **ink** and fill out **BOTH** top and bottom of form.
This form should be returned to the coach or the
athletic director to be kept on file in the athletic office.

RELEASE AND AUTHORIZATION

FOR STUDENT PARTICIPATION
IN THE WAYNE TRACE LOCAL SCHOOL DISTRICT'S
ATHLETIC PROGRAM

SPORTS: _____ STUDENT'S NAME: _____

Our son/daughter, _____ has our permission to participate in the athletic program at Wayne Trace. We hereby agree to release, discharge and/or otherwise indemnify the Wayne Trace Local School District and its employees or agents against any claim by or on behalf of the student arising as a result of our son's/daughter's participation in the athletic program. In the event of an injury, we acknowledge that we will be solely responsible for any medical expenses.

We also give permission for the school person in charge to determine whether our son/daughter should be taken for emergency medical treatment. We have instructed our son/daughter to report all injuries to the person in charge immediately.

STUDENT: _____ DATE: _____

FATHER/GUARDIAN _____ DATE: _____

MOTHER/GUARDIAN _____ DATE: _____

_____ MY CHILD DOES NOT PLAN TO PARTICIPATE IN ATHLETICS AT WAYNE TRACE.

WAIVER

WAYNE TRACE ATHLETIC INSURANCE

As parents (or guardian) of _____ we hereby state that we have insurance with:

_____

and request that the above mentioned insurance cover our child (children) for school activities.

_____ _____

(parent or guardian signature) (date)

PLEASE USE INK AND PRINT CLEARLY – fill out BOTH SIDES of form

EVERY STUDENT PARTICIPATING IN SPORTS AT WT NEEDS THIS FORM ON FILE IN THE ATHLETIC OFFICE.

ATHLETIC EMERGENCY MEDICAL AUTHORIZATION FORM

SCHOOL _____ **STUDENT NAME** _____

STUDENT ADDRESS _____ **STUDENT BIRTHDATE**_____ **GRADE** ____

Purpose – To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Residential Parent or Guardian: (please put **first** and **last** name) **Parent/Guardian Primary Phone:** _____

Parent/Guardian E-Mail: _____

Mother's Name _____ Cell phone _____

Father's Name _____ Cell phone _____

Relative or Childcare Provider we may contact if unable to reach either parent:

Name _____ Relationship _____

Cell Phone _____ Daytime phone _____

Part I or II MUST be completed.

Part I – To Grant Consent

I hereby give my consent for the following medical care providers and local hospital to be called in the event I cannot be reached:

Physician _____ Phone _____

Dentist _____ Phone _____

Medical Specialist _____ Phone _____

Local Hospital _____ Emergency Room Phone _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-mentioned doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two (2) other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairments to which the physician should be alerted: **Wears contacts/glasses (circle one)**

_____

_____

Signature of Parent/Guardian: _____ **Date:** _____

Address _____

Part II – Refusal to Consent

I do **NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

_____

_____

Signature of Parent/Guardian: _____ **Date:** _____

Address _____