

Wallenpaupack Area School District

Athletic Permission and Release/Emergency Medical Treatment Authorization/Head Injury /Equipment

Athletic Permission And Release:

The undersigned, being the parent(s) or guardian(s) of Student agree and give permission for the Student to participate in the School District athletic program described below, and the undersigned, as well as the Student, for themselves, their successors and assigns all agree to generally release and hold harmless Wallenpaupack Area School District, its directors, employees, agents, successors and assigns, of and from any and all liability, damages, expenses, costs and fees for any claim arising out of the participation of the Student in said athletic program including all transportation related to said program. It is the express understanding of the undersigned and of the Student that this participation is not required in any manner, but rather is voluntary. The undersigned and the Student assume all risks of harm arising out this activity.

PLEASE PRINT ALL INFORMATION

Sport: _____ **Student's Full Name** _____

Student's Date of Birth: _____ Grade Level: _____ (school year of participation) **2010-11**

Parent/Guardian's Name: _____

Home Address: _____

Home Phone Number: _____ Cell Phone: _____

Emergency Medical Treatment Authorization:

In the event my child is injured during a Wallenpaupack Area athletic practice or contest requiring consultation and/or treatment at a hospital or by medical personnel and the undersigned cannot be contacted, the undersigned (Parent/Guardian) of child hereby authorizes the coaching staff of the Wallenpaupack Area team to take those measures reasonably necessary to procure the required medical examination and/or treatment, including, but not limited to, authority to authorize the said examination and/or treatment by hospital or medical personnel.

Insurance Policy Information: _____

Known Allergies or Significant Health Issues:

Medications: _____ **Epipen:** ___Yes___No **Asthma:** ___Inhaler:___Yes___No

Glasses ___ **Contacts** ___

Local Physician's Name: _____ Office Telephone: _____

Risk of concussion/head injury: I hereby acknowledge that I am familiar with the nature and risk of concussion and head injury while participating in interscholastic athletics, including the risks associated with continuing to compete after a concussion or head injury.

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

Equipment Notice: I understand that I may be billed the total replacement cost in the event the equipment issued my son/daughter becomes damaged, destroyed or lost.

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____