



**MIDDLE SCHOOL SPORTS PARTICIPATION  
AND INSURANCE WAIVER  
2009/10**

**(This form must be turned in before a student can participate in the Athletic Program.)**

Student Name \_\_\_\_\_ Grade \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City Zip Code

Home Phone \_\_\_\_\_ Mother's Name \_\_\_\_\_ Business Phone \_\_\_\_\_  
Father's Name \_\_\_\_\_ Business Phone \_\_\_\_\_

Name of Medical Plan or Insurance Company \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ Policy Number \_\_\_\_\_

Group Number \_\_\_\_\_

**Please list two alternate people to be contacted if parent/guardian cannot be reached in an emergency. They must be able to drive.**

1. Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip Code

2. Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip Code

I, \_\_\_\_\_, give permission for my child to participate in the  
(Parent/Guardian)

Gross Schechter Day School Athletic Program. I do hereby release Gross Schechter Day School, its employees and agents from any and all financial responsibilities as a result of any and all injuries incurred by our child as a direct result of participation in the Athletic Program.

I (we) certify that such injuries which might be sustained by our child as a result of participation in the Athletic Program are covered by our family insurance.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

**\*\*\*\* IMPORTANT \*\*\*\*  
SEE REVERSE SIDE FOR ADDITIONAL SIGNATURES**

**Part 1: TO GRANT CONSENT**

I hereby grant consent for the following medical care providers and local hospital to be called:

Physician \_\_\_\_\_ Telephone \_\_\_\_\_

Dentist \_\_\_\_\_ Telephone \_\_\_\_\_

Local Hospital \_\_\_\_\_ Emergency Room Telephone \_\_\_\_\_

Medical Specialist \_\_\_\_\_ Telephone \_\_\_\_\_

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for 1) administration of any treatment deemed necessary by the above named 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.

Authority is granted for administration of Tylenol (aspirin is never given) and the treatment as deemed necessary for MINOR injuries at the discretion of the School Staff.

This authorization does not cover major surgery unless the medical opinions of two (2) licensed physicians or dentists are obtained prior to the performance of surgery.

Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairment to which a physician should be alerted:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

**Part 2: REFUSAL OF 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 school authorities to take the following action:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date