West Muskingum Local School District

Consent to Participate in Athletic Event:_____ **School Year:**_____

Student Name: _____ Birth Date: _____

Age:_____ Grade:_____ School: _____

Telephone No. of Student: _____

Home Address of Student *(include street, city and zip code)*: _____

Mailing Address *if different:* _____

I hereby consent to the above named student participating in the listed activity. This consent includes travel to and from the activity.

All who participate in sports at West Muskingum High School and West Muskingum Middle School must be covered with health insurance. If your family policy does not adequately cover injuries that could be sustained in sports, a school policy can be purchased for a minimal fee. Please check the appropriate box.

☐ I am adequately insured with the *(insurance company)*: _____

☐ I would like to purchase school insurance.

Parent Signature: _____

Athletic Handbook

I hereby certify that I have read and understand the West Muskingum Athletic Handbook. I understand that in order to be eligible for participation, I must comply with the rules as stated, or be subject to the penalties as outlined in the handbook.

Parent Signature: _____ Student Signature: _____

Emergency Medical Authorization

Purpose: To enable parents to authorize emergency treatment for children who become ill or injured while participating in this activity under school authority, when parents cannot be reached.

In the event after reasonable attempts to contact me have been successful, I hereby give my consent for the administration of any treatment deemed necessary by:

Doctor (preferred physician): _____ Telephone No._____

Doctor (preferred dentist): _____ Telephone No._____

or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and the transfer o the child to:

Preferred Hospital: _____

or any medical facility reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before surgery is performed.

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

_____

_____

Date:_____ Signature of Parent: _____

Address *(include city and zip code)*: _____

Telephone number to call in event of emergency: (1st) _____ Parent Name:_____

(2nd)_____ Parent Name:_____

(3rd)_____ Name of Contact Person: _____

(WMLSD:6.17.98)