COPLEY-FAIRLAWN CITY SCHOOLS
ATHLETIC MEDICAL WAIVER FORM

We grant permission for our child _____

to participate with the _____ team during the 20___ and 20___ school year. In doing so we will assume full responsibility for the payment of all medical expenses for any injury our child receives while the team is under the supervision of the Copley-Fairlawn City Schools personnel.

His/Her birthday: _____ _____ _____
month day year

Address: _____
street

_____
city state zip code

Telephone: _____

Signature of Parent or Guardian