

**WASHOE COUNTY SCHOOL DISTRICT
ATHLETIC EMERGENCY INFORMATION FORM**

Student's Name _____ Date of Birth _____

Parent/Guardian's Name _____

Address _____

Home Phone _____ Cellular Phone number(s) _____

Mother's Business Phone _____ Father's Business Phone _____

Two persons you recommend we call in the event you cannot be reached:

1. _____ Phone: _____

2. _____ Phone: _____

Preference of physicians: (Please include name, telephone number and address.)

1. _____
Name Phone Address

2. _____
Name Phone Address

Preference of Hospital: _____

Medical history and physical limitations or problems that should be known by the coach:

HEALTH/ACCIDENT INSURANCE: I understand my child/ward must be covered by health/accident insurance to participate in this athletic activity and it is solely my responsibility to ensure my child/ward is covered by health/accident insurance. By signing this form, I attest that my child/ward is covered by health/accident insurance.

As parent/legal guardian, I authorize and direct WCSD to obtain medical care for my child/ward in the event such care is necessary. I understand that, if possible, I will be contacted in the event my child/ward requires medical attention. I grant to a licensed health care provider or accredited hospital permission to perform any necessary medical and/or surgical procedures that are essential for the treatment of my child/ward and agree to be responsible for payment for such care. I release WCSD, its Board of Trustees, employees, volunteers and agents from any costs, damages, liability or loss resulting from the exercise of discretion in securing medical care for my child/ward.

Student Signature _____ Parent Signature _____

Date _____ Date _____

ORIGINAL Office
YELLOW Athletic Trainer
PINK Coach – With Athletic Eligibility Clearance Form (must have both forms before athlete can participate)