**WASHOE COUNTY SCHOOL DISTRICT**

**ATHLETIC EMERGENCY INFORMATION FORM**

LAST NAME FIRST NAME Date of Birth Grade Level

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