SYLACAUGA CITY SCHOOLS
PARENT RELEASE FOR STUDENT ATHLETES
DAY/OVERNIGHT TRIP AND EMERGENCY INFORMATION

Name: _____ DOB: _____
(Last) (First) (MI)
List Sport(s): _____
Address: _____ Grade: _____ Sex: _____
Mother/Guardian's Name: _____ Home Phone #: _____
Cell #: _____ Work #: _____ Email: _____
Father/Guardian's Name: _____ Home Phone #: _____
Cell #: _____ Work #: _____ Email: _____

IN CASE OF EMERGENCY, AND PARENT/GUARDIAN CANNOT BE REACHED, CONTACT:

Name: _____ Relationship: _____ Phone #: _____

INSURANCE INFORMATION

Insurance Co.: _____ Address (City & State): _____
Insurance Phone #: _____ Is this a PPO or HMO plan? _____
Name of Insured: _____ Group #: _____ Policy #: _____

MEDICAL INFORMATION

Family Physician: _____ Phone #: _____ Hosp. Preference: _____
Known Allergies (food, drug, insects, etc.): _____
Current Medications (inhaler, insulin, etc.): _____
Medical History (asthma, head injuries, surgeries, vision problems, blood pressure, etc.): _____
_____

Parent/Guardian Permission:
I / We give our permission for the above name student to participate in organized school athletics, realizing that such activity involves the potential for injury and/or transmittable diseases that is inherent in all sports. I / We acknowledge that even with qualified coaching, use of approved equipment, and strict safety rules; injuries and/or transmittable diseases are still a possibility. On rare occasion, these injuries and/or transmittable diseases can be so severe as to result in total disability, paralysis, or even death.

Consent for Emergency Care:
The athletic staff (athletic trainers, coaches, or other school officials) may apply first aid treatment for any injury sustained during participation sanctioned by Sylacauga City Schools. In case the parent/guardian cannot be reached, we give consent for the athletic staff to use their own judgment in securing medical aid, ambulance service, and if necessary hospital admittance when needed, as result of injury during participation in sanctioned practices/games scheduled by Sylacauga City Schools. I authorize any hospital, which has provided treatment to the above named student to surrender custody of that student to the athletic trainer or school representative upon completion of treatment. I understand that any expenses incurred will be paid for by the parent/guardian, or by insurance coverage provided by the parent/guardian, and that payment of any medical expense is not the responsibility of the school or school district. It is hereby understood that consent and authorization is hereby given and granted and intended by me to extend throughout the current school year.

_____ _____ ____/____/____
Name of Parent/Guardian (Printed) Signature of Parent/Guardian Date

_____ _____ ____/____/____
Name of Parent/Guardian (Printed) Signature of Parent/Guardian Date

_____ ____/____/____ ____/____/____
Notary Public Expiration Date Date