CLARION-GOLDFIELD-DOWS SCHOOLS MEDICAL INSURANCE & INSURANCE WAIVER

Athlete's Name _____ Year 9 10 11 12

Address _____ City _____ Zip _____

Date of Birth _____ County of Birth _____ State of Birth _____

Parent / Guardian Name: _____

Father's Home phone: _____ Father's Work: _____ Father's Work: _____

Mother's Home Phone _____ Mother's Work: _____ Mother's Cell: _____

I/We, _____, the parent/legal guardian(s) of, _____ whose

birth date is _____, give permission to qualified medical personnel to provide medical treatment to my child but only in case I cannot be contacted to give permission personally, or I am otherwise unavailable. I further give my consent for the above named student to engage in state association approved athletic activities as a representative of Clarion-Goldfield-Dows schools. I also give my consent for the above student to accompany the team as a member of out of town trips. Please provide care and treatment to minimize unnecessary pain, complications, scarring, or delays in recovery, as well as to protect life and limb.

Known allergies to antibiotics or medicines: _____

Doctor's Name _____ City _____

Day Phone _____ Emergency Night Phone_____

In EMERGENCY, if parents cannot be contacted, notify:

Name _____ Relationship _____ Phone:_____

HEALTH INSURANCE INFORMATION

Carrier _____ Policy No _____

Group No _____ Telephone Number _____

Policyholder's name: _____

Insurance and Insurance Waiver Consent:

I/We, the undersigned do not wish to purchase the school insurance provided by the school . We will cover any and all medical expenses incurred by our own son/daughter while participating in any athletic event scheduled by the school. Yes No

I/We have our own family insurance. Yes No

_____

(Signature, parent or guardian) **(Printed name)** **(Date)**