



ASSUMPTION OF RISK FOR PARTICIPATION IN VOLUNTARY SPORTS PROGRAM; WAIVER, RELEASE and INDEMNITY AGREEMENT; and MEDICAL TREATMENT AUTHORIZATION

	First	M.I.	Las t
Check All Activities	That Apply:		
☐ Flag Football	□ Volleyball	☐ Baseball	☐ Soccer
☐ Basketball	☐ Track & Field	☐ Cross Country	□ Softball
☐ Ultimate Frisbee	☐ Other:		
	elow, I hereby give p	ermission for my son/d	aughter to participate in

I am aware of the transportation arrangements for these activities and acknowledge that if the District does not provide transportation for any related event, the parents or guardians of the participating student have sole responsibility for transportation arrangements.

I am aware that the District does not provide coverage for medical treatment in connection with these activities. If a participant does not have private medical insurance, low-cost insurance is available through the District.

For and in consideration of permitting the above named child to participate in the activities checked above, the undersigned hereby voluntarily releases, discharges, waives and relinquishes any and all actions or causes of action for personal injury, bodily injury, property damage or wrongful death occurring to his/her child/ward or him/herself arising in any way whatsoever as a result of engaging in said activity, or





Health Certification for Participation in Group Sports Activities

Student's	Name:			
	First	M.I.	Last	
School Site:		Grade:	Grade:	
Ha s this s	tudent had any injury or health	n condition that should be wate	thed (yes/no)?	
If yes, ple	ase explain:			
Physiciar	n statement (please check <u>one</u>	of the following):		
a S e a h S g	to history or physical findings of thletics. He/she is authorized to tudent should have the previous valuated/treated prior to partind will not be cleared until he/ealthy enough to participate. To tudent has health problems, worden sports activities and is the articipate.	o participate in group sports ac usly mentioned health problen cipating in group sports activiti she is re-evaluated/treated an which would prohibit him/her fr	ctivities. n and/or injury ies d proven	
D	OCTOR'S SIGNATURE	STATE LICENSE	DATE	
	Please provide stamp	from the doctor's office/clinic/hospital	in this box:	

activities incidental thereto, wherever or however the same may occur and for whatever period said activities may continue.

The undersigned does for him/herself, his/her heirs, executors, administrators and assigns hereby release, waive, discharge and relinquish any action or causes of action, aforesaid, which may hereafter arise for him/herself or for his/her estate, and agrees that under no circumstances will he/she or his/her heirs, executors, administrators and assigns prosecute or present any claim for personal injury, bodily injury, property damage or wrongful death against the District or any of its officers, agents, or employees for any of said causes of action, whether the same shall arise by the negligence of any said persons, or otherwise.

I have read and understand the foregoing, and have voluntarily signed this agreement.

I am aware of the potential risks involved with this activity and I am fully aware of the legal consequences of signing this agreement.

Health	or Other Special Needs: (Initial or	ne)		
	Participant has no special health medication is required.	needs that staff should be aware of, and no		
Participant has a special need, and instructions are attached. Number of attached pages Other:				
are consid	dered necessary in the best judgment	sent to whatever x-ray examination, anesthetic, nt, emergency transportation and hospital care of the attending physician, surgeon or dentist, of the medical staff of the hospital or facility		
Parent/Gua	ardian Signature	Date		
Print Parent	t/Guardian Name	Phone Number		