Columbia Community Unit District No. 4

ATHLETIC and ACTIVITY CONSENT/WAIVER

I permit _____(Student's Name) to participate in the Columbia Community Unit No. 4 Interscholastic Athletic Program and/or curricular/co-curricular activities. I hereby release the aforesaid District, coaches, and employees from any liability, except that liability for which they are legally responsible, for any injury or damage that may be sustained by said child on account of his/her participation in said Interscholastic Athletic Program or activity or transportation connected thereto.

I further agree to purchase the medical insurance offered by Columbia Community Unit District No. 4, or alternatively have, in full force and effect, medical coverage through a private insurance company. I assume any medical expenses not covered by said health insurance.

I am the parent/guardian of the above student. I certify that my child/ward is in good physical health and is capable of participation in sports or activities. No need exists to limit his/her participation. I assume full responsibility for his/her physical condition and participation. I will notify you of any changes in his/her physical condition.

In the event reasonable attempts to contact me at the locations listed below have been unsuccessful, I, as parent or legal guardian of the above student, do hereby authorize (1) the treatment by a qualified and licensed medical doctor of my child/ward in the event of a medical emergency which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment or undue discomfort if delayed; and (2) the transfer of my child/ward to any hospital reasonably accessible.

This release form is completed and signed of my own free will with the purpose of authorizing medical treatment under emergency circumstances in my absence. This will remain in effect for the school year in which it was signed.

Name and relation to student (please print):	**Home Phone:**	**Cell/Other Phone:**
Emergency contact:	**Home Phone:**	**Cell/Other Phone:**
Physician's name:	**Physician's Phone:**	
Hospital of Choice:	**Hospital's Phone:**	

Please list specific medical allergies, medicines, or other conditions_____

_____

_____

Signature of Parent/Guardian: _____Date_____

3/2011