Student Name:____

MEDICAL INSURANCE FORM

MUST BE COMPLETED IN ORDER TO PARTICIPATE

*NOTE: It is district policy that all students participating in athletics be covered by insurance.

Is school health insurance needed____YES____NO.

If "yes", insurance policies are available in Post Falls Middle School's office or online at www.k12specialmarkets.com.

If "no", is your child covered by a family health insurance policy? YES____ NO____

______________________________	____
Insurance Company	Student Name (Please Print)
______________________________	____
Policy#	Signature of Parent or Guardian
_______________________________	____
Subscriber	Parent Emergency Phone Number

CONSENT FORM

I hereby consent to the above named student participating in the interscholastic athletic program at Post Falls Middle School. This consent includes travel to/from athletic contests and practice sessions. I further consent to treatment deemed necessary by physicians designated by school authorities for any illness or injury resulting from his/her athletic participation.

Signature of Parent/Guardian____ Date_________

My participation in interscholastic athletics for Post Falls Middle School is voluntary on my part, and with the understanding that I have not violated any of the eligibility rules and regulations of the state association.

Signature of Student____ Date__________

*Note: The original copy is to be returned to the school.