SCENIC ATHLETIC PARTICIPATION PERMIT

COMPLETED FORM REQUIRED EACH SCHOOL YEAR

SCHOOL YEAR 20___ **BIRTH DATE** ____/____/____ **GRADE** 6 7 8

STUDENT NAME LAST FIRST INITIAL

FALL SPORT _____
WINTER SPORT _____
SPRING SPORT _____

EMERGENCY INFORMATION

PREFERRED CONTACT _____

MOTHER _____ **PHONE** _____

FATHER _____ **PHONE** _____

ADDRESS _____

HOME PHONE _____

PHYSICIAN _____ **PHONE** _____

If doctor can't be reached, may one be chosen by the D6 person in charge? YES[ ] NO[ ]

EMERGENCY CONTACT IF PARENTS CAN'T BE REACHED

NAME _____ **PHONE** _____
ADDRESS _____ **RELATIONSHIP** _____
NAME _____ **PHONE** _____
ADDRESS _____ **RELATIONSHIP** _____

Permission is hereby given in the event emergency medical treatment is immediately required and either parent or guardian cannot be reached.

PARENT SIGNATURE _____ **DATE** _____

PARENT/GUARDIAN ACTIVITIES PERMISSION

_____ has my permission to participate in sports/activities approved by the Board of Education of District #6 and to go with the coach/advisor on any regular scheduled trips. I understand my student may be transported on a Special Pupil Activity Bus or Motor Coach. While I expect school authorities to exercise reasonable precautions to avoid injury, I understand they assume no financial obligation for any injury that may occur. I am advised students are held responsible for all equipment owned by the school.

PARENT SIGNATURE _____ DATE ____/ ___/____

INSURANCE ARRANGEMENTS

INDIVIDUALS ARE NOT ALLOWED TO PARTICIPATE UNLESS COVERED BY INSURANCE. School District #6 makes available a low-cost insurance program for students. This insurance can be waived if the participant is covered by the parent or guardian's personal insurance program.

Please mark one of the following boxes
[ ] I am purchasing the accident Insurance policy made available through District #6 which pays a percent of the cost of injury as stated on the insurance policy.

[ ] I hereby waive the insurance made available through School District 6 for my child as I will provide my current personal insurance.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO REPORT ANY CHANGES IN INSURANCE OR PHYSICIAN TO THE CRATER ACTIVITIES OFFICE.

He/ She will be covered by the following insurance program and no medical payment is expected from the insurance available through School District 6.

PARENT SIGNATURE _____

Insurance Company _____
Address_____
Phone _____
Group# _____ID# _____