FOR EMERGENCY USE ONLY

I hereby give my consent for__________________________ to compete in University Interscholastic League approved sports, and travel with the coach or representative of the school on any trips.

It is understood that even though protective equipment is worn by the athlete whenever needed, the possibility of an accident still remains. Neither the University Interscholastic League nor the high school assumes any responsibility in case an accident occurs.

I have read and understand the University Interscholastic League rules and agree that my son/daughter will abide by all of the University Interscholastic League rules.

If, in the judgment of any representatives of the school, the above student needs immediate care and treatment as a result of any injury or sickness, I do hereby REQUEST, AUTHORIZE, AND CONSENT to such care and treatment as may be given to said student by any physician, athletic trainer, nurse, hospital, or school representative; and I do hereby agree to indemnify and save harmless the school and any school representative from any claim by any person whomsoever on account of such care and treatment of said student.

Signed this_______ day of __________________, 20____

Signature of Parent or Guardian X ___________________________________

Signature of Student X ____

Home Address____

City/State/Zip____

Home Phone # (____) _____________ Work # (____) _________________

Activities to participate in: (please circle)

Volleyball Baseball
Football Softball
Cross Country Golf
Tennis Powerlifting
Cheerleading Drill Team
Wrestling Soccer
Basketball Track

WALLER ISD STUDENT ACTIVITY EMERGENCY INFORMATION CARD

Student/Athlete Name____ School Year___________ Grade: 9th 10th 11th 12th

Date of Birth: _________________________ Sex: ______________ SSN#_______________________________________

Address _____________________________________ City____________ Zip________ Phone#_______________________

Male Parent/Guardian Name _______________________________Address if Different______________________________

Female Parent/Guardian Name ______________________________Address if Different_____________________________

Mom's Work ______________________________________ Dad's Work ____

If Parents cannot be reached, notify _________________Phone # ____________________ Relationship_________________

Blood Type _____________ Last Tetanus Shot____________ Allergies ____

Family Physician ___________________________________ Physician's Phone # _________________-________________

Insurance Co. Name _________________________________ Phone #______________________HMO or PPO __________

Address of Insurance Company _____________________________ Group/Policy No._______________________________
Student Covered under this insurance Yes/NO

Any medication taken routinely: Yes or No If yes, please explain ____

If there are any other circumstances, conditions, or drug and food allergies that you feel should be taken into consideration by the WISD athletic training staff, please explain ____