

**WHITEFISH HIGH SCHOOL
ACTIVITIES RELEASE FORM**

STUDENT NAME: _____ **GRADE:** _____ **DATE:** _____

PART A: PARENT/GUARDIAN PERMISSION TO PARTICIPATE

WE HEREBY GIVE OUR PERMISSION FOR THE ABOVE NAMED STUDENT TO ENGAGE IN WHITEFISH HIGH SCHOOL DISTRICT APPROVED INTERSCHOLASTIC ACTIVITIES AS A REPRESENTATIVE OF HIS/HER SCHOOL. WE ALSO GIVE OUR CONSENT FOR THE ABOVE NAMED STUDENT TO ACCOMPANY THE TEAM/GROUP AS A MEMBER ON ITS OUT-OF-TOWN TRIPS. WE UNDERSTAND THAT WE MUST HAVE OUR OWN INSURANCE OR PURCHASE THE PLAN AVAILABLE. CHECK ONE:

- CARRY OUR OWN INSURANCE INSURANCE CO. _____
INSURANCE COMPANY _____ PHONE NUMBER _____
PLAN _____ GROUP # _____
POLICY HOLDER _____ ID # _____
- WE AGREE TO PURCHASE THE INSURANCE PLAN AVAILABLE AND HAVE ATTACHED THE COMPLETED FORM WITH CASH OR CHECK AS REQUIRED.

PART B: PARENT/GUARDIAN AND STUDENT RISK AWARENESS

WE UNDERSTAND AND ACKNOWLEDGE THAT ORGANIZED SECONDARY ATHLETICS INVOLVE THE POTENTIAL OF INJURY THAT IS INHERENT IN ALL SPORTS/ACTIVITIES. WE ACKNOWLEDGE THAT EVEN WITH THE BEST PROCEDURES, USE OF PROTECTIVE EQUIPMENT AND STRICT OBSERVANCE OF THE RULES, INJURIES ARE STILL A POSSIBILITY. ON RARE OCCASIONS, THESE INJURIES CAN BE SO SEVERE AS TO RESULT IN TOTAL DISABILITY, PARALYSIS OR EVEN DEATH.

PART C: TRAINING RULES FROM STUDENT HANDBOOK

IN SIGNING, WE ACKNOWLEDGE THAT WE HAVE READ AND UNDERSTAND THE TRAINING RULES AND POLICIES OF THE WHITEFISH SCHOOL DISTRICT NO.44 PRESENTED IN THE STUDENT ATHLETE HANDBOOK, WITH THE PURPOSE TO INSURE THE SAFETY OF STUDENTS AND TO MAINTAIN THE INTEGRITY OF THE ACTIVITIES COVERED BY THESE RULES.

PART D: MEDICAL CONSENT

WE HEREBY GIVE OUR CONSENT, IN THE EVENT OF INJURY OR ILLNESS, FOR EMERGENCY MEDICAL TREATMENT, HOSPITALIZATION OR OTHER MEDICAL TREATMENT AS MY BE NECESSARY FOR THE WELFARE OF THE ABOVE NAMED STUDENT, BY A PHYSICIAN, QUALIFIED NURSE, EMERGENCY MEDICAL PERSONNEL, CERTIFIED ATHLETIC TRAINER, AND/OR HOSPITAL DURING ALL PERIODS OF TIME IN WHICH THE STUDENT IS AWAY FROM HIS/HER LEGAL RESIDENCE AS A MEMBER OF AN INTERSCHOLASTIC ACTIVITY TEAM/GROUP. FURTHERMORE, WE HEREBY WAIVE, ON BEHALF OF THE ABOVE NAMED STUDENT, AND OURSELVES ANY LIABILITY OF THE SCHOOL DISTRICT, ITS AGENTS OR EMPLOYEES, ARISING OUT OF SUCH MEDICAL TREATMENT.

STUDENT NAME: _____ DOB: _____ MALE FEMALE
FAMILY DOCTOR: _____ DR. PHONE # _____
ALLERGIES: _____

ALLERGIES TO MEDICATIONS: _____

CURRENT MEDICATIONS AND USE: _____

PLEASE LIST CHRONIC ILLNESS, HEART CONDITIONS, ASTHMA, EPILEPSY, DIABETES AND OTHER INFORMATION TO INFORM MEDICAL PERSONNEL PRIOR TO TREATMENT.

EMERGENCY CONTACT: _____ EMERGENCY PHONE # _____

RELATIONSHIP TO ATHLETE: _____

SECONDARY CONTACT: _____ PHONE # _____

RELATIONSHIP TO ATHLETE: _____

WE, THE UNDERSIGNED, ACKNOWLEDGE THAT WE HAVE READ AND UNDERSTAND ALL ASPECTS OF THIS FORM AND GRANT PERMISSION AND CONSENT AS REQUIRED. WE UNDERSTAND THAT WE ARE ENCOURAGED TO CLARIFY ANY QUESTION WE MAY HAVE WITH THE ACTIVITIES DIRECTOR PRIOR TO SIGNING THIS FORM.

PARENT/GUARDIAN SIGNATURE

DATE

STUDENT SIGNATURE

DATE