WCS ATHLETICS WAIVER

5th-8th Grade Students, 2020-2021 School Year

Student(s), _____
has my permission to participate in Physical Education programs, training, competition, events, activities and travel sponsored by or representing the Worthington Christian School. I approve of the leaders who will be in charge of these programs and activities. I recognize that the leaders are serving to the best of their abilities. I certify that the participant has full medical insurance with the company listed below. I understand and agree that this document will be kept in the possession of authorized adult personnel and that reasonable care will be used to keep this information confidential. I agree to allow the authorized adult personnel to release this information in the event of a medical emergency to a third party medical provider. I certify to the best of my knowledge that the participant named hereon is physically fit to engage in the activities described above. I also understand that while precautions are taken to prevent possible injuries, accidents can and do happen, and in the event that my child is injured during a WCS-sponsored event, I will not hold the school liable.

I do also hereby grant my permission for my child(ren) to be transported by school-sponsored and/or approved vehicles (including personal vehicles as necessary) to athletic events during the duration of the school year.

Parent/Guardian Name (print):

_____

Parent/Guardian Signature: Date:

_____ _____

Relationship to Participant(s): _____

If, during the course of my daughter's/son's physical/sports activities, she/he should become ill or sustain an injury, I hereby **authorize** WCS personnel to obtain emergency medical/dental care. I will assume financial responsibility for the bills incurred through my insurance company.

Parent/Guardian Signature: Date:

_____ _____

OR

I **do not authorize** emergency medical/dental care for my daughter/son.

Parent/Guardian Signature: Date:

_____ _____

REQUIRED:

Primary Insurance Company (or "none" if you do not have health insurance): Primary Group/Policy #:

_____ _____

Family Physician Name: Physician Phone #:

_____ _____

1 FORM PER FAMILY

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