PROOF OF INSURANCE
MEDICAL RELEASE/CONSENT FORM

Name of insurance company:_____

Address:_____

Group #:_____ Policy #:_____ Phone:_____

Primary physician:_____ Preferred hospital:_____

ACKNOWLEDGEMENT OF RISK/CONSENT TO PARTICIPATE
CONSENT TO PERFORM PHYSICAL EXAMINATION

_____ has parental consent to participate in _____.
Athlete's name sport

And receive a physical examination by the team physician or equal representative as deemed qualified by Keystone School District. I/We hereby acknowledge an awareness that participation in athletics involves a risk of injury, which may include severe injuries possibly involving paralysis, permanent mental disability or death, and that these injuries may occur in some instances as the result of unavoidable accidents. By signing this form, the parent acknowledges the risks involved and understands that the school will not be held responsible for any injury or damage. The parent/guardian assumes full responsibility for any injury or damage to his/her child through his/her hospital/insurance plan and accepts that Keystone School District will not be financially responsible for such instances. If the parent/guardian does not sign this form relieving the Keystone School District, it's coaches, certified athletic trainer, student athletic trainers, administrators, and other school officials from all responsibility regarding any injury or damage sustained during participation in interscholastic activities, his/her child will not be permitted to participate in that activity.

_____
signature of parent/guardian

ATHLETIC TRAINING CARE/EMERGENCY AUTHORIZATION

I give permission to the Certified Athletic Trainer to evaluate, treat, and rehabilitate and recondition any injury sustained by my son/daughter during the course of an athletic season as she/he deems appropriate. This may or may not involve application of modalities. I hereby acknowledge that the Certified Athletic Trainer my contact the student's physician in order to obtain information concerning the extent of the injuries sustained, the extent to which a student may participate, and what additional treatment the physician may recommend. I hereby consent to the Certified Athletic Trainer to contact physicians, nurses, and hospitals/clinics to access my son/daughter's medical records that relate to PIAA eligibility. Information obtained by the ATC will be considered confidential and will be kept in compliance with HIPPA law. I also give my permission to the ATC employed by Keystone School District to perform immediate and emergency treatment to injuries incurred during any interscholastic activity involving Keystone teams, and if necessary, to transport him/her to the nearest medical facility. I give consent to the hospital or physician(s) to perform or administer emergency care to my son/daughter as deemed appropriate.

_____
signature of parent/guardian