** 8001 NW 5th Street, Plantation, FL 33324**

**School: (954) 370 2161**

**Email:** [**school@oursaviorplantation.org**](mailto:school@oursaviorplantation.org)

[**www.oursaviorplantation.org**](http://www.oursaviorplantation.org)

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***ATHLETICS - Parental Waiver and Consent Form***

As the parent or legal guardian of the child named below, I hereby give my full consent and approval for my child to participate as a team member in all after school sports offered by Our Savior Lutheran Schools Athletic Program throughout the school calendar year 2018-2019.

I understand that there are certain risks of injury inherent in the practice and play of each sport, as well as in traveling and other related activities incidental to my child’s participation, and I am willing to assume these risks on behalf of my child. I hereby certify that my child is fully capable of participating in the designated sport and that my child is healthy and has no physical or mental disabilities or infirmities that would restrict full participation in these activities.

In addition to giving my full consent for my child’s participation, I do hereby waive, release and hold harmless the school or facility that we participate in games or practices, including Our Savior Lutheran School, its Officers, coaches and sponsors, supervisors and representatives for any injury that may be suffered by my child in the norm al course of participation in the designated sport and the activities incidental thereto, whether the result of negligence or any other cause. I understand that no accident or medical insurance is provided with this activity.

I am signing this form and I am stating that my child’s health records are up-to-date and my child has passed a sports physical examination covering them for the current school year. I give my permission for my child to be transported by designated volunteers to and from any program and/or activity.

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***Name of Student*** ***Printed Name of Parent/Guardian******Signature of Parent/Guardian***

***Prior Consent and Authorization for Medical Treatment***

**Parent Contact Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If parents cannot be reached in an emergency, contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to Student \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Family Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Under the name of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Special Medications/Allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I authorize and consent to any X-ray examination, anesthetic, medical, dental, or surgical diagnosis or treatment, and hospital care which, in the best judgment of a licensed physician or dentist, is deemed advisable. I agree to assume financial responsibility for expenses incurred as a result of those services provided, including emergency medical transportation.

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***Signature of Parent/Guardian******Date***