WMRSD ATHLETICS PROOF OF INSURANCE FORM

To the Parent/Guardian:

A. In case of an injury acquired during a co-curricular, interscholastic competition, or athletic practice, I consent to have my son or daughter examined and if treatment is required, to be treated by a physician or hospital. I am of the understanding that in case of any injury that is thought to require an examination by a physician every effort will be made by the school to contact me before taking the student to a physician or hospital. If, however, I cannot be notified, the school has my permission to take appropriate steps to insure the safety and well-being of my child.

B. I understand that any and all expenses incurred in the examination or treatments of my child are my responsibility. My child is covered by medical/health care insurance for any injuries through the following insurance program.

Insurance Company: _____

Insurance Policy Number: _____

Parent/Guardian's Signature: _____