WILLIAMSBURG COMMUNITY SCHOOLS
ATHLETIC EMERGENCY TREATMENT RELEASE FORM

(One Per Family)

Student Name:_____ M or F Birthdate:_____ Grade:_____

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Student Name:_____ M or F Birthdate:_____ Grade:_____

Student Name:_____ M or F Birthdate:_____ Grade:_____

Student Name:_____ M or F Birthdate:_____ Grade:_____

Fathers Name:_____ Emergency Phone Number:_____

Mothers Name:_____ Emergency Phone Number:_____

Emergency Contact:_____Relationship:_____Phone Number:_____

Emergency Contact:_____Relationship:_____Phone Number:_____

Insurance Company:_____Policy #:_____

DOCTOR_____IS TO BE CALLED AT PARENTS EXPENSE IN CASE OF AN EMERGENCY. IF IT SHOULD BECOME NECESSARY, TAKE STUDENT TO_____HOSPITAL AT_____CITY AT THE PARENTS EXPENSE. WE WOULD TAKE THIS STEP ONLY IF WE COULDN'T CONTACT YOU FIRST.

As a parent/guardian, I do herby give permission to an authorized school official to obtain professional medical attention to my child(ren) listed above which in the opinion of the attending physician, may endanger his or her life, cause disfigurement, physical impairment, or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

THIS RELEASE FORM IS COMPLETED AND SIGNED OF MY OWN FREE WILL WITH THE SOLE PURPOSE OF AUTHORIZED TREATMENT UNDER EMERGENCY CIRCUMSTANCES IN MY ABSENCE.

PARENT/GUARDIAN SIGNTUARE:_____ DATE:_____

THIS FORM IS GOOD FROM AUGUST 1, 2017 - JULY 31, 2018