Dakota Jr/Sr High School SY2018-2019 Athletic Information

Athletic Handbook Acknowledgement - Athletic/Activity Permission Form - Insurance Waiver

_____ _____

LAST NAME (student) First Middle Grade Entering

_____ _____

Residential Address City/State/Zip Home Phone

*I certify that this address is our **primary residence.** If there is a change of address, documentation needs to be given to the school district when a move takes place.* Parent/Guardian Initials _____

With whom does the student reside with?_____

Athletic Handbook Sign Off: I am familiar with and understand that a copy of the **2018-2019 Dakota Student Athletic Handbook** which summarizes rules and regulations regarding school policies, athletic eligibility and the high school athletics training process has been made available on the school website or a hard copy has been made available upon request.

_____ _____

Parent/ Guardian Initials Student Initials

Athletic Permission to Participate: I hereby give (Student's Name) _____ my consent to participate in the sports listed here: _____. Furthermore, it is my understanding that an annual physician's report must be on file at the high school. I grant Monroe Clinic athletic training staff permission to assess and/or treat injuries.

_____ _____

Parent/ Guardian Initials Student Initials

Athletic Participation Insurance Waiver: Dakota School District #201 Board Policy requires all athletes to carry either school insurance or requires parents to certify that their son/daughter is covered by their family insurance.

This is to certify that said athlete:_____ has my permission to participate in all types of athletics and desire to have waivered the administrative regulations requiring school insurance before participation is permitted. This also is to certify that I _____, parent/guardian, of the above named person will assume the financial responsibility that may be covered by said present school insurance, as approved by the Board of Education, Community Unit District #201, Dakota, Illinois.

Signed:_____

Parent/Guardian

_____ _____ _____

Insurance Company **Insured Parent** **Policy Number (must be filled in)**

If I can not be reached and if in the judgement of school authorities immediate medical attention is indicated, I authorize responsible school personnel permission for emergency treatment or to send my child to an available doctor or hospital.

Hospital Preference:_____ Parent Initials:_____

_____

Parent Signature **Student Signature** **Date**