SUMMIT CHRISTIAN ACADEMY
ATHLETIC PERMIT

Student: _____ Age: _____ Grade: _____

Address: _____ City: _____ State: _____ Zip: _____

Birth Date: _____ Home Phone: _____ Cell Phone: _____

Physician: _____ Physician Phone: _____

INSURANCE RELEASE

This is to certify that we have **adequate insurance** protection for our son/daughter while practicing or participating in Interscholastic Sports, or other school sponsored activities.

Name of Company and Type of Policy: _____

_____ _____

Parent/Guardian's Signature **Date**

EQUIPMENT/UNIFORM AGREEMENT

I/We the undersigned hereby agree to be responsible for the safe return of **all** athletic equipment and/or uniforms issued by the school to the above name student. If said equipment and/or uniforms are not or can not be returned, I/we will pay for the replacement costs of the said items.

_____ _____

Parent/Guardian's Signature **Date**

PERMISSION TO PARTICIPATE

I/We the undersigned acknowledge that even with the best coaching and strict observances of all rules, accidents my occur. My/Our above named student has permission to practice and compete in the inter- scholastic program. I/We agree for our student to be transported by bus and/or private parent vehicles.

_____ _____

Parent/Guardian's Signature **Date**

EMERGENCY MEDICAL CARE RELEASE

I/We the undersigned parent(s) or legal guardian of the minor(s) listed below:

_____ _____

Minor's Full Name **Date of Birth**

Do hereby authorize any X-Ray examination, anesthetic, dental, medical, or surgical or treatment by/from the nearest licensed medical facility that may be rendered to said minor under the general, specific or special consent of: Summit Christian Academy Coaching Staff, the temporary custodian of the minor: whether such diagnosis or treatment is rendered at the office of a licensed medical physician or dentist, or at another licensed medical facility. I/We authorize the physician or dentist to call any necessary consultants, at his/her discretion. I/We also authorize officials to secure the use of an ambulance, if necessary for transporting my/our child to the hospital. I further agree to pay the medical facility and ambulance service for all service rendered to the above named minor.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required, but is given to encourage those persons who have temporary custody of the minor, and said physician or dentist to exercise his/her best judgment as to the requirements of such diagnosis or medical, dental, or surgical treatment.

This consent shall remain effective until _____a.m./p.m. on the day of _____, 20___, unless sooner revoked in writing delivered to said physician or dentist or to said persons entrusted with the custody, care and control of said minor child or children.

If the above arrangement is not satisfactory, what would you like for us to do with your child in case he/she is injured or becomes seriously ill. Please attach a sheet with specific directions for emergency care.

DATE: _____ WITNESS (other than custodian): _____

FATHER'S SIGNATURE: _____ MOTHER'S SIGNATURE: _____

LEGAL GUARDIAN: _____ HOME #: _____ OTHER #: _____

FAMILY DOCTOR: _____ OFFICE #: _____ HOSPITAL PREFERRED: _____

ALLERGIES: _____ DATE OF LAST TETANUS: _____

INSURANCE COMPANY: _____ POLICY HOLDER & #: _____