

WESTERN HEIGHTS ATHLETIC DEPARTMENT
Athlete Information Form

Name _____ Phone _____

Parent(s) _____

Parent Home Phone(s) _____

Parent Work Phone(s) _____

Parent Cell Phone(s) _____

Emergency Contact(s) _____

AUTHORIZATION TO TREAT A MINOR

I, the undersigned parent or legal guardian of _____, authorize any hospital, clinic, or licensed physicians to treat my child, charge with any x-ray examination, anesthetic, medical or surgical diagnosis rendered under the general or special supervision of any member of staff of the hospital/clinic or office of a physician who are licensed to practice in the State of Oklahoma or state in which above said participant is competing or traveling.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority and power to render care when the physician in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but treatment will not be withheld if the undersigned cannot be reached.

X _____
Signature of Parent/Guardian Date

INSURANCE VERIFICATION

In order for a student to participate in athletics, he/she must have adequate insurance. This can be purchased through the school or through a private insurer. Please fill out the information below.

_____ We have purchased school insurance.

_____ We have private insurance with _____
Policy Number _____

X _____
Signature of Parent/Guardian Date