

WALTHAM HIGH SCHOOL
617 LEXINGTON ST
WALTHAM, MA 02452
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DEPARTMENT OF ATHLETICS
WILLIAM FOLEY, ATH. DIRECTOR
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ATHLETICS FAX # 781-314-5496

INTERSCHOLASTIC ATHLETIC PARENTAL PERMISSION FORM

Student Name _____ Grade _____ Birth Date _____

Address _____ Zip Code _____ Male / Female (circle one)

Father (Guardian) _____ Mother (Guardian) _____

Home Phone # _____ Home Phone # _____

Work / Cell Phone # _____ Work / Cell Phone # _____

Family Physician _____ Telephone # _____

Insurance Company _____ Subscriber Name _____

Policy # _____ Group # _____

SPORTS

_____ FALL _____ WINTER _____ SPRING _____

The Waltham Public School system has provided each athlete with an insurance policy that covers injuries sustained while involved in interscholastic athletics. This policy is strictly non-duplicating, which means that it will only pay for medical expenses incurred over and above your own health insurance coverage.

Permission is granted to the Team Physician, Athletic Trainer, and Coaching Staff to provide the needed emergency treatment to the athlete prior to referral to a medical facility.

I agree to submit a recent physical exam report from my family health care provider or, if not available, I give the team physician permission to perform a pre-sport screening on my son/daughter.

I have read and understand the statements on this form and give permission for my son/daughter to participate in interscholastic sports, and accompany the team on the bus for out-of-town events.

Date _____ Parent/Guardian Signature _____

SCHOOL USE ONLY

Physician _____ Date _____ A.T. _____