

FOR EMERGENCY USE ONLY

I hereby give my consent for _____ to compete in University Interscholastic League approved sports, and travel with the coach or representative of the school on any trips.

It is understood that even though protective equipment is worn by the athlete whenever needed, the possibility of an accident still remains. Neither the University Interscholastic League nor the high school assumes any responsibility in case an accident occurs.

I have read and understand the University Interscholastic League rules and agree that my son/daughter will abide by all of the University Interscholastic League rules.

If, in the judgment of any representatives of the school, the above student needs immediate care and treatment as a result of any injury or sickness, I do hereby REQUEST, AUTHORIZE, AND CONSENT to such care and treatment as may be given to said student by any physician, athletic trainer, nurse, hospital, or school representative; and I do hereby agree to indemnify and save harmless the school and any school representative from any claim by any person whomsoever on account of such care and treatment of said student.

Signed this _____ day of _____, 20____

Activities to participate in: (please circle)

Signature of Parent or Guardian _____

Signature of Student _____

Home Address _____

City/State/Zip _____

Home Phone # (____) _____ Work # (____) _____

Volleyball	Baseball
Football	Softball
Cross Country	Golf
Tennis	Powerlifting
Cheerleading	Drill Team
Wrestling	Soccer
Basketball	Track

WALLER ISD -- STUDENT ACTIVITY EMERGENCY CARD

Revised 4/01

Student/Athlete Name _____ School Year _____ Grade _____

Date of Birth _____ Sex _____ SSN# _____

Address _____ City _____ Zip _____ Phone# _____

Male Parent/ Guardian Name _____ Address if Different _____

Female Parent/ Guardian Name _____ Address if Different _____

Parents' Phone _____ Mom's Work _____ Dad's Work _____

If Parents cannot be reached, notify _____ Phone# _____ Relationship _____

Blood Type _____ Last Tetnus Shot _____ Allergies _____

Family Physician _____ Physician's Phone # _____

Hospitalization Insurance Co. Name _____ HMO or PPO ? _____

Address of Insurance Company _____ Group / Policy No. _____

Any medication taken routinely: YES or NO If yes, please explain _____

If there are any other circumstances or conditions that you feel should be taken into consideration by the WISD staff, please explain _____