

SOUHEGAN HIGH SCHOOL
ATHLETIC CERTIFICATE OF INSURANCE

I, _____ hereby certify with my signature below, that I have medical and/or health insurance which covers my son/daughter _____. This policy will provide primary coverage for him/her in the event of injury while in any interscholastic or intramural sport at Souhegan High School.

Date _____ Parent's Signature _____

I, _____ DO NOT have medical and/or health insurance to cover my child's _____ participation in athletics. I understand the school does not cover my child and that there is an insurance plan available to me to participate in if I fill out the required forms and purchase it (high school interscholastic football is not covered under the regular policy but can be purchased separately). The school athletic department has these forms.

Date _____ Parent's Signature _____

CONSENT TO PARTICIPATE AND ACKNOWLEDGEMENT OF RISKS

I/we hereby acknowledge an awareness that participating in the sport of _____ involves a risk of injury, which may include sever injuries possibly involving paralysis, permanent mental disability, or death, and that these injuries may occur in some instances as the result of unavoidable accidents. I/we accept these risks in giving consent to participation in _____ during the _____ season by the undersigned athlete.

Athlete's Full Name

Date of Birth

Athlete's Signature

Date

Father or Guardian

Date

Mother or Guardian

Date

PARENTAL CONSENT FORM
For Medical Care of a Child

I am the parent or legal guardian of _____,
minor, and have full legal custody and control of the minor.

I hereby authorize _____ **A Souhegan High School Representative** _____, to consent to whatever medical care (including diagnostic examination, treatment or immunization) that my son/daughter may require during my absence. This authorization is conditioned upon the understanding that, in the event of serious illness or injury or the need for surgery or other major procedure other than in an emergency, the temporary guardian will use all reasonable efforts to contact me. Failure to successfully contact me, however, should not delay or prevent any licensed physician from providing such treatment as may be advised in my child's best interest.

This authorization is valid from _____ to _____
(Date) (Date)

(Date) (Signature of Parent or Legal Guardian)

NAME OF CHILD _____ AGE _____

PARENT (S) _____

WORKPLACE (FATHER) _____ WORKPLACE (MOTHER) _____

PHONE (FATHER) _____ PHONE (MOTHER) _____

HOME PHONE _____

HEALTH INSURANCE COMPANY _____

HEALTH INSURANCE IDENTIFICATION NUMBER _____

In the event of my absence or unavailability, my preferences are as follows:

Ambulance _____ Phone _____

Hospital _____ Phone _____

Family Physician _____ Phone _____

General Surgeon _____ Phone _____

Orthopedic Surgeon _____ Phone _____

Other Physician(s) _____ Phone _____

_____ Phone _____

Pharmacy _____ Phone _____

List any medication the child is currently using _____

Date of last tetanus _____

Any know allergies/adverse drug reactions _____
