ATHLETIC INSURANCE WAIVER

NAME OF STUDENT ATHLETE____________________________________

Present Address_____________________________Phone__________

Parent's Place of Employment – Father______________________
Mother______________________

Family Physician____

Family Dentist____

Name of Private Insurance Carrier and Address______________

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Policy Number and Expiration Date__________________________

I hereby give my permission for the above named student to practice and compete, representing Oregon Middle School, in W.I.A.A. approved interscholastic sports. I further grant permission for my son/daughter named above, to be given immediate emergency care in case of injury as a result of athletic competition by the team physician or any other physician present.

I understand that by signing this waiver, payment required for medical treatment of an injury as a result of athletic competition will be assured by the above identified policy and not by any policy carried by the school.

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Parent Signature

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Date