COACH/SPORT	GR	ADE	
	Spring View Mide Sport/Activity Participation P		
Date	_		
	ctivity.		
My child is covered by:			
Insurance Plan:	No		
Policy Holder's Name:			
Family Physician:			
Physician's Phone number:		_	
Parent's/Guardians Name:		Home phone:	
Mother's cell:			
Father's cell:			
MEDICAL CONCERNS:			
Under state law, school districts injury insurance that covers me district offering insurance or otl qualify to enroll in no-cost or lowhich include other comparable may be obtained by calling 1-80 1-800-880-5305.  Medical insurance is necessary for	s are required to ensure that all mendical and hospital expenses. This is ther health benefits that cover medical eno-cost local, state or federally insure no-cost or low-cost local, state or 0-722-3365 or the Healthy Families or a student-athlete to participate on a must purchase medical insurance on ne of the agencies listed above.	mbers of school athletic tean nsurance requirement can be call and hospital expenses. Some program. Information at federally sponsored health and Medical Programs Information at the school athletic team. If your statement is sent to the school athletic team.	ms have accidental be met by the school Some pupils may bout these programs insurance programs, rmation Line at
	the parents cannot be reached, con		
		Phone:	
of the school to make such arrancare. This includes necessary tra	emergency, if a parent/guardian can ngements as he/she considers necess ansportation. I further authorize th by any licensed physician or surgeo	sary for my child to receive to the physician named above to	medical or hospital

The undersigned hereby agrees to bear all costs incurred as a result of the foregoing.

Signature of Parent/Guardian

Date