

WEST ESSEX REGIONAL SCHOOL DISTRICT
Athletic Department

PARENT PERMISSION

Student/Athlete Name: _____ Grade: _____

I wish to participate in the following sport/activity: _____

Season/Year : _____

Home Phone Number: _____

Mother's Name and Business/Cell Number: _____

Father's Name and Business/Cell Number: _____

Emergency Contacts if Parent Cannot be reached:

1. _____
(Name/Relation) (Home Phone No.) (Business/Cell Phone No.)

2. _____
(Name/Relation) (Home Phone No.) (Business/Cell Phone No.)

I give permission for the school nurse/school physician to share pertinent medical information with the athletic trainer and/or coach on a need to know basis:

_____ **YES** _____ **NO**

With my full knowledge and consent, my **son/daughter** _____ may participate in all physical activities and may take trips that are part of this program. The school authorities will exercise maximum care in the administration and control of athletic activities in order to safeguard participants against injury and accident. Realizing that such activity involves the potential for injury which is inherent in all sports, I acknowledge that even with the best coaching, use of the most advanced protective equipment and strict observance of rules, injuries are still a possibility. On rare occasions these injuries can be so severe as to result in total disability, paralysis or even death. I acknowledge that I have read and understand this warning.

I certify that the information provided herein is accurate as of the date of this signature.

(Student Signature) (Date)

(Parent or Legal Guardian Signature) (Date)