

SHAWSHEEN VALLEY TECHNICAL HIGH SCHOOL

In consideration of my son/daughter/ward's participation in the interscholastic sport listed below, at Shawsheen Valley Technical High School, I hereby release and agree to hold harmless Shawsheen Valley Technical High School, The Shawsheen Valley Regional School District and any and all parties from all liability in case of accident, injury, damage or other mishap in connection with all medical services or athletic trainer services they provide. This includes, but no limitation of the foregoing, all liability for damages of every kind, nature or description now existing or which may hereafter arise from or out of injuries and damage known and unknown, permanent or otherwise, received by my son/daughter/ward while participating in the interscholastic sport listed below.

I have read and understand the above statement and agree to its terms as stated.

_____	_____
Date	Parent/Guardian's Signature
_____	_____
Sport	Student's Name (Please Print)

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**PERMISSION TO AUTHORIZE MEDICAL TREATMENT**

Student's Name \_\_\_\_\_

Address: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Insurance: \_\_\_\_\_ Policy No: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Home Number: \_\_\_\_\_ Emergency Contact Cell Number: \_\_\_\_\_

In order to ensure proper medical treatment, please list all medical conditions (information is confidential):

\_\_\_\_\_  
List allergies to medications:

\_\_\_\_\_  
In the event of an injury to my son/daughter/ward, while participating as a member of an interscholastic athletic program at Shawsheen Valley Technical High School, I hereby grant permission to the Athletic Trainer and/or a member of the coaching staff to authorize medical treatment by a licensed physician for my son/daughter/ward in my absence. I hereby authorize the above parties to release and share any necessary information needed to treat a specific injury or condition, whether pre-existing or acute. Any athlete who is referred to a physician for medical treatment must have clearance from that physician in conjunction with the athletic trainer on staff.

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Sport