

**Saint John Liability Release, Medical Treatment Consent
Insurance Information and Acknowledgement of Physical Form**

I, _____, individually and as a parent or guardian
(Name of Parent or Legal Guardian)

of, _____, a minor, for and in consideration of the
(Name of Student Athlete)

Privilege of participating in athletic activities at Saint John the Evangelist Catholic School, Fenton, Michigan, do hereby remise, release and forever discharge the said St. John the Evangelist Catholic School, its officers, teachers, employees, agents and any and every person associated with the operation of the school from any liability, claims, or demands for damages on account of any injuries which may be sustained by said minor in connection with or as a result of participation in such athletic activities.

I also hereby agree to indemnify and defend Saint John the Evangelist Catholic School against any loss, damage, or cost incurred or suffered as a result of any action, claim, or demand by the said minor or by any other person on his/her behalf or his/her benefit.

I further understand that it is my responsibility to obtain medical insurance for my daughter/son to cover any injuries they may incur.

I also give my permission for any and all medical attention necessary to be administered to my child in the event of an accident, injury, sickness, etc. under the direction of their coach or another responsible team supervision (including parents, teachers, school or church employees and administrators). This would include transportation to a medical facility if it is determined to be necessary by the above mentioned coach/supervisor. I also hereby assume the responsibility for payment of such treatment.

I FURTHER UNDERSTAND THAT MY DAUGHTER/SON must HAVE A CURRENT Medical Physical Form on file with the school office before she/he is allowed, BY STATE LAW, to begin practicing with the team

I acknowledge that I understand and will abide by the above mentioned statements.

SIGNATURE OF PARENT/GUARDIAN: _____ Date: _____

INSURANCE COMPANY: _____

POLICY NUMBER: _____ GROUP NUMBER _____

FAMILY PHYSICIAN: _____

PHYSICIAN PHONE NUMBER: _____

FAMILY PHYSICIAN ADDRESS: _____

MY CHILDS KNOWN ALLERGIES: _____