

**Bandera ISD Athletic Participation/Emergency Information Form**  
**(PLEASE PRINT)**

Student Name: \_\_\_\_\_ Grade(2009/10 year): \_\_\_\_\_ DOB: \_\_\_\_\_  
List Sports: \_\_\_\_\_ Sex (M/F): \_\_\_\_\_ Age: \_\_\_\_\_  
Student ID/SSN: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Parent Work #: \_\_\_\_\_  
Home Address: \_\_\_\_\_ Zip: \_\_\_\_\_ Please answer the following questions:  
Diabetes \_\_\_\_\_ Epilepsy \_\_\_\_\_ Heart Trouble \_\_\_\_\_ Blood Type \_\_\_\_\_ Metal Pins \_\_\_\_\_ Contacts/glasses \_\_\_\_\_  
Medical History (Surgeries, Fractures, Chronic Problems, Other): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to any medication?  Yes  No If yes, list: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Emergency Contacts**

1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_

Name	Relationship	Phone Number(s)
------	--------------	-----------------

**STUDENT ATHLETE INSURANCE INFORMATION**

All students who participate in athletics are required to take out school insurance or have their parents/guardian sign this waiver releasing the Bandera ISD from all liability incurred in any athletic event.

Under the optional school sponsored insurance plan, the athlete is covered while practicing or participating in regularly scheduled athletic activities, however, **high school football participants (grades 9-12) must pay for the Football Insurance Program in order to be covered under the voluntary student insurance plan.**

We, the parents of the above named student, have studied the Athletic Insurance Program sponsored by Bandera ISD and will not hold the school district responsible for medical or hospital coverage above the amount specified in the athletic policy.

The Bandera ISD has our permission to provide immediate care, treatment, and emergency services in case of injury or illness.

**PLEASE MARK YOUR CHOICE:**

- 1. School Insurance Plan (information will be distributed after 08/01/09)
- 2. I assume all medical expenses in the event of an injury.
- 3. We have our own hospitalization plan.

Insurance Co: \_\_\_\_\_ Policy #: \_\_\_\_\_ Policy Holder: \_\_\_\_\_  
Group #: \_\_\_\_\_ Plan #: \_\_\_\_\_ Holder's Employer: \_\_\_\_\_  
Address: \_\_\_\_\_ City, State/Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

**ALL CLAIMS AGAINST THE SCHOOL SYSTEM FOR INJURIES ARE HEREBY WAIVED.**

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_