

**IMMACULATE CONCEPTION SCHOOL**

321 SOUTH METTER AVENUE

COLUMBIA, ILLINOIS 62236

618-281-5353

Mission \* Community \* Service

Athletic Activities

Consent and Medical Treatment

I/We, the parent(s)/guardian(s) of \_\_\_\_\_ request that Immaculate Conception School allow my son/daughter to participate in \_\_\_\_\_.

In consideration for allowing above named student to participate in this athletic activity, we hereby release and save harmless the School and all its' employees from any and all liability arising to my/ our son/daughter as a result of participation.

We further authorize any emergency medical treatment, including hospitalization, that may be necessary as a result of any accident or injury arising from participation in the above activity and assume responsibility for payment thereof. We understand that this authorization is in advance of any diagnosis and is given as authority to render any treatment deemed necessary.

Parent(s)or Guardian(s) signature(s)\_\_\_\_\_

Date: \_\_\_\_\_

**Student Information**

Name:\_\_\_\_\_ Birthdate:\_\_\_\_\_

Name:\_\_\_\_\_ Birthdate:\_\_\_\_\_

Name:\_\_\_\_\_ Birthdate:\_\_\_\_\_

Name:\_\_\_\_\_ Birthdate:\_\_\_\_\_

Phone Number:\_\_\_\_\_

Special Medical Needs:\_\_\_\_\_

Father's Name:\_\_\_\_\_ Mother's Name:\_\_\_\_\_

Work Phone Number:\_\_\_\_\_ Work Phone Number:\_\_\_\_\_

Insurance Company for Hospitalization:\_\_\_\_\_

Policy Number:\_\_\_\_\_