WESTLAKE CITY SCHOOL DISTRICT
ATHLETIC MEDICAL WAIVER FORM

WE GRANT PERMISSION FOR OUR CHILD, _____

TO PARTICIPATE WITH THE WESTLAKE CITY SCHOOLS ATHLETIC TEAMS DURING THE ____-____ SCHOOL YEAR. IN DOING SO, WE WILL ASSUME FULL RESPONSIBILITY FOR THE PAYMENT OF ALL MEDICAL EXPENSES FOR ANY INJURY OUR CHILD RECEIVES WHILE THE TEAM IS UNDER THE SUPERVISION OF THE WESTLAKE SCHOOL PERSONNEL

HIS/HER BIRTHDAY: _____ _____ _____
MONTH DAY YEAR

ADDRESS: _____

_____
CITY STATE ZIP

TELEPHONE: _____

_____
Signature of Parent or Guardian Date