

# Crosby Independent School District Medical and Travel Release

Name \_\_\_\_\_ Nickname \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Grade \_\_\_\_ Sex: M\_\_\_\_ F\_\_\_\_

Parent's Name: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Another Person to Contact: \_\_\_\_\_

Relationship to Athlete: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Name: \_\_\_\_\_

Policy No.: \_\_\_\_\_

Allergies: \_\_\_\_\_

I hereby authorize the Athletic Trainer to treat the above athlete as needed. I understand this treatment may include ibuprofen.

I also authorize the trainer, administrator, or coach in charge as agent to the above athlete, to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by and is to be rendered under the general or special supervision of any physician or surgeon licensed under the provision of the Medical Practice Act, whether such diagnosis or treatment be rendered at the office or hospital.

\_\_\_\_\_  
Signature of Parent or Guardian

This is to certify that \_\_\_\_\_ has my permission to travel to and from athletic competitions related to his/her participation in UIL sports. I understand that the Crosby Independent School District Athletic policy requires students to ride the bus to and from all athletic events and departure from this requirement will release Crosby Independent School District from all liability for any adverse results that may occur.

I agree to release Crosby Independent School District and its employees from all liability with reference to the above-stated transportation.

This form must be on file in the Athletic Office prior to participation in CISD athletics.

\_\_\_\_\_  
Signature of Parent or Guardian