LA CONNER SCHOOL DISTRICT

INFORMED CONSENT FORM RE: WRESTLING

Student Name: _____ *Birth Date:* _____

School: _____ *Grade:* _____

We accept and understand that the sport of **wrestling** involves certain inherent risks, dangers and hazards that may cause serious personal injury, including death, severe paralysis or brain injury necessitating long term care and significantly impairing enjoyment of life or life activities. We accept and understand that the above-described injuries and other injuries, including but not limited to: concussions; serious neck and spinal injuries potentially resulting in complete or partial paralysis; brain damage; blindness; serious injury to all internal organs; serious injury to all bones, joints, ligaments, muscles and tendons; contusions; dislocations; sprains; strains; and fractures, may occur as a result of participating in this sport.

We understand that the inherent risks of this sport cannot be eliminated without jeopardizing the essential qualities of the sport. We have reviewed all of these risks and we understand and appreciate them and still desire to participate in the activity.
(Student Initial)_____ (Parent Initial)_____

We certify that (Student Name) _____has no medical or physical conditions which could interfere with or compromise his/her safety in participating in this activity.
(Student Initial)_____ (Parent Initial)_____

I authorize qualified emergency medical professionals to examine, and in the event of an injury or serious illness, to administer emergency medical care to the above-named student.
(Parent Initial)_____

In the event it becomes necessary for school district staff to obtain emergency medical care for the above-named student, we understand that neither the staff member nor the school district assumes financial liability for the expenses incurred because of the accident, injury, illness and/or unforeseen circumstances.
(Student Initial)_____ (Parent Initial)_____

I certify that my household has sufficient medical insurance to facilitate any necessary medical care or resultant care for any injury that may be sustained by the above-named student.
(Parent Initial)_____

HAVING READ AND INITIALED THE STATEMENTS ABOVE, I ACKNOWLEDGE THAT I HAVE READ THIS DOCUMENT AND FULLY UNDERSTAND THE RISKS ASSOCIATED WITH PARTICIPATING IN THIS VOLUNTARY SCHOOL DISTRICT ATHLETIC PROGRAM. BY SIGNING BELOW, I CERTIFY THAT I HAVE READ THE ABOVE, UNDERSTAND ITS CONTENT AND WISH TO PARTICIPATE.

_____	_____	_____
Student name (please print)	Student signature	Date

HAVING READ AND INITIALED THE STATEMENTS ABOVE, I ACKNOWLEDGE THAT I HAVE READ THIS DOCUMENT AND FULLY UNDERSTAND THE RISKS ASSOCIATED WITH PARTICIPATING IN THIS VOLUNTARY SCHOOL DISTRICT ATHLETIC PROGRAM. BY SIGNING BELOW, I CERTIFY THAT I HAVE READ THE ABOVE, UNDERSTAND ITS CONTENT AND GIVE MY PERMISSION FOR MY STUDENT TO PARTICIPATE.

_____	_____	_____
Parent/guardian name (please print)	Parent/guardian signature	Date