



**COLONIAL CHRISTIAN SCHOOL
MEDICAL RELEASE FORM/WAIVER FORM**

8140 Union Chapel Road, Indianapolis, Indiana 46240
(317) 253-0649

This is intended to be a legally binding document.

I, hereby, give my permission for _____
(Name of Player)

to be transported to/from off-site practices with either a coach or responsible player (as determined by the Athletic Director/Coach at the beginning of the season). I assume full responsibility for my son/daughter while he/she rides to practices and agree that he/she be in submission to those in authority.

As a parent or guardian, I do, herewith, authorize the treatment by a qualified and licensed medical doctor of the following student, in the event a medical emergency which, in the opinion of the attending physician, may endanger his or her life, cause disfigurement, physical impairment or undue discomfort if delayed. This authorization is granted only after a reasonable effort has been made to reach me.

I, hereby, agree to observe all regulations and to comply with those in authority while participating in these events.

(Signature of Participant)

Date

Parent/Guardian Signature

Primary phone number

Secondary phone number