LAS VEGAS CITY SCHOOLS
ATHLETIC DEPARTMENT
901 Douglas Ave.
Las Vegas, NM
(505) 454-5770
Fax: (505) 454-5776
jcfulgenzi@hotmail.com

Juan Carlos Fulgenzi – Director of Co-Curricular Activities

Appendix D
LAS VEGAS CITY SCHOOLS
Emergency Information/Insurance Form

Parental Consent
I hereby give my consent for ___________________________________ to participate in interscholastic athletics. I understand that the financial responsibility for securing care of athletic injuries is a matter between the parent/guardian and all medical personnel necessary. Las Vegas City Schools may not pay doctors, dentists or hospitals for any treatment or rehabilitation of any child.

Parent Initials _____

Insurance
YES We have applied for student accident insurance through the Las Vegas City Schools.
- Or -
YES We have accident insurance with ________________________________, _______________________
(Name of Insurance Company) *(Policy #)*

Medical History
I hereby state that I have reviewed the medical history of my child/ward and find the answers to the questions correct to the best of my knowledge. (Required for legal minors)

Parent Initials _____

Authorization for Medical Services
I/we request that I/we be contacted within a reasonable time in the event of illness or injury requiring medical service. In the event I/we cannot be reached, I/we, parent(s)/guardian(s) hereby designate the Athletic Director, Team Coach, Athletic Trainer, or his/her designee to act in my/our behalf for medical services. In the event we cannot be reached, and the situation calls for medical attention, we recognize and relinquish our responsibility to a practicing physician and/or medical personnel acting in the best interest of my/our child/ward. I/we hereby assume financial responsibility for all medical treatment and rehabilitation provided.

Parent Initials _____

Family Physician: ______________________________ Phone #: ______________________________

Address: ____
Street *City* *State* *Zip*

Family Dentist: ________________________________ Phone #: ______________________________

Address: ____
Street *City* *State* *Zip*

Hospital Preference: ____

Parent/Guardian Name: _____________________ Wk. Phn: ________________ Hm. Phn. ________________

Responsible Person: _________________________ Wk. Phn: ________________ Hm. Phn. _______________

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Personal Medication Notification

For my own protection, I, the student-athlete, will inform the athletic trainer and/or medical doctors if I am taking any medication or using any ointment, liniments, balms, or have a metal implant in my body before receiving therapy or treatment of any kind in the training room. Any combination of the above and deep heat therapy could cause serious complications.

I/We parent(s), guardian(s), and student-athlete have read and understand the above document and agree to its contents.

__________________________________ ______________________________

Parent/Legal Guardian Signature **Date**