EMERGENCY MEDICAL TREATMENT AND INSURANCE VERIFICATION FORM

I hereby authorize The SEED School to obtain through a physician/hospital of its choice, any emergency care that may become reasonably necessary for the athlete in the course of athletic activities or travel. I guarantee payment for all medical services incurred by either the insurance company listed below or myself.

Student Name (Print): _____

Parent/Guardian (Print): _____

Parent/Guardian (Signature) _____

Date: _____

Family Physician: _____

Physician's Phone Number: _____

Affiliated Hospital: _____

Medical Insurance: _____

Policy Number: _____

Policy Holder: _____

The aforementioned insurance company will be responsible for medical or surgical expenses resulting from any injury, major or minor, incurred by the student named above during any practice or athletic contest sponsored by The SEED School of Maryland. In conjunction, the student shall also be covered by the aforementioned company for any injury that may occur while traveling to or from athletic contests. Therefore, we, the parents/guardians of the student named above agree to release The SEED School of Maryland, or any part thereof, from any obligation as pertains to the financial responsibility in these matters for the2016 – 2017 school year, or any period thereafter.

Note: All forms are to be turned into the Athletic Office.