

LITTLE ROCK SCHOOL DISTRICT
PARENT'S ATHLETIC CONSENT FORM

SCHOOL _____ GRADE _____ DATE _____

NAME OF STUDENT _____ STUDENT ID # _____

SPORT(S) _____

SEX (CIRCLE ONE): MALE FEMALE **RACE(CIRCLE ONE):** BLACK WHITE HISPANIC OTHER

BIRTHDATE: ___/___/_____

WE, THE PARENTS/GUARDIANS OF THE ABOVE NAMED STUDENT HEREBY GIVE OUR CONSENT AND PERMISSION FOR HIM/HER TO PARTICIPATE IN THE ABOVE NAMED SPORT(S).

WE ARE AWARE THAT ATHLETIC INSURANCE PROVIDED BY THE DISTRICT COVERS ALL STUDENTS WHILE THEY ARE PARTICIPATING IN SPORTS AND ARKANSAS ACTIVITIES ASSOCIATION (AAA) ACTIVITIES THAT ARE SCHOOL SCHEDULED, SCHOOL SUPERVISED AND SCHOOL FUNDED DURING THE REGULAR SCHOOL TERM. PARTICIPANTS ARE ALSO COVERED WHILE THEY ARE TRAVELING AS A SPONSORED GROUP IN A SCHOOL ASSIGNED CAR, BUS OR VAN OPERATED BY A LICENSED DRIVER OVER THE AGE 21 TO AND FROM THE SCHOOL AND A COVERED EVENT SITE, AND WHILE STAYING OVERNIGHT, AS A SCHOOL SUPERVISED GROUP, DURING A COVERED EVENT HELD AWAY FROM THE HOME SCHOOL. THIS INSURANCE IS "EXCESS".

CATASTROPHIC INSURANCE COVERAGE IS ALSO PROVIDED BY THE AAA AND THE DISTRICT FOR ALL SR.HIGH AND MIDDLE SCHOOL ATHLETES RESPECTIVELY. THIS POLICY PAYS BENEFITS FOR SPECIFIC LOSSES FROM ACCIDENT ONLY AND HAS A \$25,000 DEDUCTIBLE TO COMPLIMENT THE DISTRICT'S EXCESS POLICY.

WE REALIZE THAT PARTICIPATION IN SUCH ACTIVITY INVOLVES THE POTENTIAL FOR INJURY INHERENT IN ALL SPORTS. WE ACKNOWLEDGE THAT EVEN WITH THE BEST COACHING, THE BEST EQUIPMENT AND STRICT OBSERVANCE OF REASONABLE AND PRUDENT ACTIVITIES, INJURIES OF A SERIOUS NATURE MAY RESULT. IN SOME RARE INSTANCES DISABILITY OR DEATH MAY OCCUR. WE WILL NOT HOLD THE LITTLE ROCK SCHOOL DISTRICT RESPONSIBLE FOR INJURIES RESULTING FROM PARTICIPATION IN THE DISTRICT SPORTS PROGRAMS.

WE HEREBY GRANT PERMISSION TO QUALIFIED MEMBERS OF THE SCHOOL'S STAFF TO ADMINISTER EMERGENCY FIRST AID IN CASE OF INJURY OR ILLNESS TO OUR CHILD. WE FURTHER GRANT PERMISSION TO QUALIFIED MEMBERS OF A MEDICAL ORGANIZATION OR QUALIFIED PHYSICIAN TO TREAT OUR CHILD IN CASES WHERE IT IS DEEMED TO BE A LIFE-TREATENING ILLNESS OR INJURY.

WE **DO** OR **DO NOT** HAVE A PERSONAL OR GROUP INSURANCE POLICY. (CIRCLE ONE)

NAME OF INSURANCE COMPANY _____

POLICY NUMBER _____ AGENT _____

PARENT OR GUARDIAN SIGNATURE