



Light of Christ Catholic Schools

School attending: _____ Grade: _____ Activity: _____

I give my permission for _____ (student name) to compete for Light of Christ Schools. I also acknowledge that injuries may occur as a result of my child's participation in this activity. In the event of an injury requiring medical attention, I hereby grant permission for emergency medical treatment for my daughter/son. I understand that the cost for medical attention will be the responsibility of the parents/guardians.

Father's Name: _____ Mother's Name: _____

Address: _____ Home Phone: _____

Email: _____

Father's work #: _____ Cell Phone #: _____

Mother's work #: _____ Cell Phone #: _____

In the event of an injury/emergency when parents **cannot** be reached, I would like these contacts to be attempted in the following order.

	<u>Name</u>	<u>Phone Number</u>	<u>Relation to athlete</u>
1 st			
2 nd			

Does your child have any allergies and/or medical concerns that the coach should be aware of?

Yes (If yes, the child's Student Health Information Sheet will be attached to this form for the coach)

No

Parent/Guardian Signature: _____ Date: _____

I will pay by check now (Check # _____)
Elementary: \$50/activity (\$150 max)
Academy: \$75/activity (\$225 max)
High School: \$100/activity (\$300 max)

Please apply to my FACTS account
Fee will be applied to next FACTS payment. If account is paid in full, a payment will be added to 1st of upcoming month