Grace Academy Parent Release Form

I. TRANSPORTATION PERMISSION

Applicant has permission to (check as many as apply to your student):

_____ Drive his/her own car to/from athletic practices/games.
_____ Ride with student drivers to/from athletic practices/games.
_____ Ride with other parent to/from athletic practices/games.
_____ Ride with coach/staff to/from athletic practices/games.

II. AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS

If your child needs medical, dental, health, or hospital services, you as parent must give permission. It's the law. This is a legal document. With it, you may appoint relatives, friends, teachers, coaches, anyone over 18 years of age, to be responsible for your child when you are away from them.

III. AUTHORIZATION OF CONCUSSION STATEMENT FORM

A parent must read and sign the Parent Concussion Statement at the beginning of each sport's season, as advised by the Centers for Disease Control.

GRACE ACADEMY POLICY: ALL ATHLETES MUST BE COVERED BY PERSONAL MEDICAL INSURANCE TO PARTICIPATE IN THE ATHLETIC PROGRAM AT GRACE ACADEMY.

Name of Minor _____ Birth Date _____
Identify allergies or special conditions _____

I/We, being the parent(s) or legal guardian(s) of the above named minor, do hereby appoint: (yourself, friend, or family):

Name _____ Phone 1 _____
Address Phone 2 _____
City/State/Zip _____
AND Grace Academy Staff and Coaching Staff (704) 234-0292
PO Box 2553, Matthews, NC 28106

TO ACT IN MY/OUR BEHALF IN AUTHORIZING UNEXPECTED MEDICAL, DENTAL, SURGICAL CARE AND HOSPITALIZATION FOR THE ABOVE NAMED MINOR DURING THE PERIOD OF MY/OUR ABSENCE FROM:
AUGUST 1, 2024 THROUGH MAY 30, 2025.

The parent or legal guardian set forth in this form does hereby agree to hold harmless the person appointed and a physician providing treatment from and against any and all loss, cost, damage, or expense of any kind arising out of or in connection with that person's or physician's acting in reliance upon the authorization set forth herein, with the exception of actions which amount to gross negligence. The physician shall not be relieved on the basis of this authorization for liability for negligence in the diagnosis and treatment of a minor.

THIS DOCUMENT SHALL BE PRESENTED TO A PHYSICIAN, DENTAL, OR APPROPRIATE HOSPITAL REPRESENTATIVE AT SUCH TIME AS UNEXPECTED MEDICAL, DENTAL, SURGICAL CARE OR HOSPITALIZATION MAY BE REQUIRED.

Parent/Guardian Signature	Parent/Guardian Signature
Address Date	Address Date
Witness Signature (other than minor)	Witness Signature (other than minor)
Address Date	Address Date

HOSPITALIZATION COVERAGE FOR ABOVE NAMED MINOR:

(All athletes MUST have medical insurance to participate in the athletic program at Grace Academy)

Insurance Co. _____ I.D. or Group No. _____
Named of Insured _____ SSN of Insured _____
Date _____ Athlete SSN _____
Family Physician _____ Physician's Phone No. _____
Physician's Address _____

PHOTOCOPY FRONT AND BACK OF INSURANCE CARD, AND ATTACH TO THIS FORM.