

ATHLETIC PARTICIPATION FORM

SCHOOL YEAR _____ PRESENT GRADE _____ SPORT _____

Please Complete The Following Vital Information

Legal Last Name _____ First Name _____ Middle Name _____

Birthdate _____ Social Security No. _____ Sex _____

Address _____ Phone No. _____

Father/Legal Guardian Name _____ Work Place _____ Work Phone No. _____

Mother/Legal Guardian Name _____ Work Place _____ Work Phone No. _____

Emergency Contact

Name _____ Relationship to Student _____ Phone No. _____

Name _____ Relationship to Student _____ Phone No. _____

Medical Release

Family Physician _____ Address _____ Phone No. _____

Does your child have any medical problems such as: seizures, drug allergies, nose bleeding, unusual reaction to insect bites, asthma or diabetes?

Please List _____

Does your child take any medication on a regular basis?

Please List _____

I give permission to the attending trainers, physician and medics at athletic games to carry out such emergency diagnostic and therapeutic procedures as may be necessary for my child, and also permit such procedures to be carried out at and by one of the local hospitals in the event that my child has been sent or taken there for emergency care.

Parent/Guardian Signature _____ Date _____

Proof of Insurance

The Board of Education requires that all students participating in athletics be covered by an insurance plan that will offer benefits in the event of accidental injury. This requirement may be met by providing proof of insurance through the parent's health insurance program or by purchasing insurance offered through the school system. Student athletes who are unable to provide proof of insurance coverage will be required to enroll in the school time accident plan or the 24 hour accident plan prior to participating in any sport except football. Student athletes in the football program will have to be enrolled in the interscholastic football plan. Please review your health insurance to assure proper protection for your child.

Name of Insurance Company _____ Name of Subscriber _____ Policy No. _____ Group No. _____

We feel that our family insurance is adequate and that additional coverage is not necessary at this time for our child.

Parent/Guardian Signature _____ Date _____