f. Athletic Insurance-Medical Forms

1) Combination Participation, Physical Examination and Emergency Medical Form

ATHLETIC PARTICIPATION FORM

STUDENT INFORMATION _____ _____ _____
NAME AS IT APPEARS ON BIRTH CERTIFICATE | GRADE | DATE OF BIRTH

Special Attendance Permit (CIRCLE ONE): Yes No
Administrative Transfer (CIRCLE ONE): Yes No

RESIDENCE: _____ _____ Since _____
Street Address | City | M/D/Y

Within the _____ High School attendance boundaries.

PREVIOUS RESIDENCE: _____ _____ Since _____
Street Address | City | M/D/Y

Within the _____ High School attendance boundaries. From _____ To _____
M/D/Y M/D/Y

INSURANCE: One or more of the following plans must be in force: _____ _____
COMPANY NAME | POLICY NO.

(1) Individual or Group Health/Accident insurance:
(2) Special Athletic Insurance purchased (CIRCLE WHICH SPORT): FOOTBALL SOCCER
(3) Student Classroom Accident Insurance purchased: (CIRCLE WHICH PLAN): 9 HOUR 24 HOUR

EMERGENCY MEDICAL TREATMENT PERMISSION AND INFORMATION

I hereby authorize the school to obtain, through a physician of its own choice, any emergency care that may become reasonably necessary for the student in the course of athletic activities or travel. Payment of all charges incurred for medical treatment is guaranteed by me or the insurance company providing coverage for above-named student.

(1) Allergies and/or special medical problems (list medications carried by student) _____
(2) Date of last Tetanus shot _____ (3) Family Physician _____ Phone _____

STUDENT PARTICIPATION PERMISSION

Participation in competitive athletics may result in severe injury, including paralysis, or death. Improvement in equipment, medical treatment and physical conditioning, as well as rule changes, have reduced theses risks, but is impossible to totally eliminate such occurrences from athletics. I hereby give my consent for the above-named student to represent his/her school in athletic activities, including team travel for local or out-of-town trips, except for those activities crossed out below:

Baseball	Cross Country	Football Fall/Spring	Soccer	Swimming/Diving	Track	Weightlifting
Basketball	Cheerleading	Golf	Softball	Tennis	Volleyball	Wrestling

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STATEMENT: The above-named student has resided with me continuously for one (1) calendar year and I do hereby certify that **I have read this form and understand the rules contained herein, and that the information supplied is true and correct to the best of my knowledge. I understand that this student must continue to reside with me to maintain eligibility.** I accept the responsibility to inform the school of any future change of this information.

_____ School Attended last year _____
Student's Signature

_____ _____ _____ _____
Signature of Legal Parent/Guardian | Home/Work Telephone | Date | Relationship to Student

_____ _____ _____ _____
Legal Signature of Parent/Guardian | Home/Work Telephone | Date | Relationship to Student

If only one Parent/Guardian signature above, explain reason: _____

AFFIDAVIT PHYSICIAN COMPLETE THIS SECTION

STATE OF_____
COUNTY OF _____
Before me this day personally appeared _____ who, being duly sworn, deposes and states that all of the above information is correct.

_____
Signature of person making affidavit) Sworn to and subscribed before me this
_____ day of _____
A.D., 20 ____

_____
Notary Public
My commission expires ____

HEALTH EXAMINATION (on file in Registrar's office)

Health examination for athletes should be rendered after August 1 preceding school year concerned.

AGE _____ HEIGHT _____ WEIGHT _____ BLOOD PRESSURE _____

LIST SIGNIFICANT PAST ILLNESS OR INJURY

EYES _____ R20/ :L20/ HEARING _____ R /15:L /15
CARDIOVASCULAR_____ RESPIRATORY _____
SPLEEN_____ LIVER _____
MUSCULO-SKELETAL_____ HERNIA _____
NEUROLOGICAL_____ SKIN _____
URINALYSIS_____ GENITALIA _____

COMMENTS

I have examined this pupil and find him/her physically able to compete in supervised activities NOT CROSSED OUT BELOW:

Baseball Cross Country Football Fall/Spring Soccer Swimming/Diving Track Weightlifting
Basketball Cheerleading Golf Softball Tennis Volleyball Wrestling*

*Minimum weight at which this student may wrestle is _____ pounds.
SIGNATURE OF EXAMINING PHYSICIAN _____ DATE _____
ADDRESS OF PHYSICIAN _____ PHONE _____

ACTIVITIES ADMINISTRATOR'S COPY - White Original COACHES' COPY - Yellow PARENTS' COPY - Pink

2) Emergency Medical Authorization (simplified)

_____**SCHOOL DISTRICT**

ATHLETIC DEPARTMENT

EMERGENCY MEDICAL AUTHORIZATION

This form must be made available by the coach at all team practices and contest for each team member to ensure proper medical treatment by physicians or hospital in the event of serious injury.

Athlete's Name _____

Birth Date _____ Grade _____ Sex _____

Parents' Name _____

Home Phone _____ Business Phone _____

Address _____ Zip _____

In the event the parents cannot be contacted, please contact:

_____ at phone # _____

List sports the above-named athlete plays:

1. _____

2. _____

3. _____

I hereby give my consent for medical treatment deemed necessary by physicians designated by school authorities and/or for transportation to a hospital emergency room for treatment for any illness or injury resulting from his/her athletic participation.

Preferred physician _____

Preferred hospital _____

I understand this authorization will only be enforced when I cannot personally be contacted and provide for immediate treatment.

_____ _____

Signed (Parent or Guardian) Date

3) Emergency medical authorization

_____ **HIGH SCHOOL**

EMERGENCY MEDICAL AUTHORIZATION

_____	_____	_____	_____
Student's Name	Date of Birth	School Attending	Bus Number
_____	_____	_____	_____
Address	Zip Code	Telephone #	Neighbor or Alternate Contact
_____	(If unlisted, circle the telephone #)	_____	
Parents'/Custodian's Names		Telephone # Where Alternate Can Be Reached	
_____	_____	_____	
Custodial Parent in Case of Separation	Grade	Neighbor or Alternate Contact	
		_____	
		Telephone # of Alternate Contact	

Purpose: To enable parents to authorize emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached.

(Part I or II Must Be Completed)
PART I - TO GRANT CONSENT

In the event reasonable attempts to contact me, _____ (Name of Parent), at _____ (Phone #) or _____ (alternate) at _____ (phone #) have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. _____

(preferred physician) Phone # _____ or Dr. _____ (preferred dentist)

phone # _____, or, in the event the designated preferred practitioner is not available, by another

licensed physician or dentist; and (2) the transfer of the child to _____ (preferred

hospital) phone # _____ or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before surgery is performed.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairment to which a physician should be alerted: _____

_____

_____

_____	_____	_____
Date	Signature of Parent/Custodian	Address

If you wish school to take no emergency medical action, do **not** sign this portion but fill out Part II.

(Do Not Complete Part II If You Completed Part I)

PART II - REFUSAL TO CONSENT

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to:

_____

_____

_____

_____

_____ _____

Date Signature of Parent/Custodian

_____

Address

4) Emergency Room Treatment Permission

_____ HIGH SCHOOL
EMERGENCY ROOM TREATMENT PERMISSION

All blanks on this page must be filled in. Print carefully. Give your full name - no nicknames!

PLEASE PRINT

NAME_____ CLASS _____
(Last) (First) (Middle)

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE# _____ BIRTH DATE_____ AGE _____

HEIGHT _____WEIGHT _____

PARENT'S NAME _____

PLACE OF EMPLOYMENT _____ OCCUPATION _____

BUSINESS PHONE # _____ FAMILY PHYSICIAN _____

HAVE YOU BEEN TREATED AT _____ HOSPITAL BEFORE? _____YES _____NO

DO YOU HAVE HOSPITAL INSURANCE? _____YES _____NO

IF YES, COMPANY NAME _____ POLICY # _____

NOTICE TO PARENTS

WE NEED YOUR PERMISSION TO TREAT YOUR SON/DAUGHTER IN CASE OF EMERGENCY AT PRACTICE SESSIONS OR DURING ANY ATHLETIC EVENT.

THE TEAM'S PHYSICIANS, DRS. _____ARE AVAILABLE FOR SUCH TREATMENT. IF YOU WISH TO USE THE SERVICES OF ONE OF THESE PHYSICIANS AT _____HOSPITAL, PLEASE SIGN BELOW.

YOU HAVE MY PERMISSION TO HAVE MY SON/DAUGHTER _____
TREATED BY ONE OF THE ABOVE PHYSICIANS AND I ALSO GIVE _____ HOSPITAL PERMISSION TO GIVE EMERGENCY TREATMENT AND X-RAYS WHEN NECESSARY.

_____
(Parent's Signature)

IF YOU PREFER ANOTHER DOCTOR TO TREAT YOUR SON/DAUGHTER, REALIZING THAT TREATMENT CANNOT START UNTIL THE DOCTOR IS LOCATED, PLEASE STATE THE NAME OF THE DOCTOR AND THE HOSPITAL DESIRED.

I PREFER THAT MY SON/DAUGHTER _____ BE TREATED FOR INJURIES BY

_____ _____
(Physician's Name) (Physician's Telephone #)

_____ _____
(Hospital Preferred by Parents) Parents' Signature