

ELMWOOD PARK SCHOOL DISTRICT

INTERSCHOLASTIC ATHLETIC PERMISSION FORM

Student's Name: _____

Grade: _____ School Year: _____ Sport: _____

I. Consent of Parent/ Guardian

I hereby give my consent for my child to participate in interscholastic athletics in the Elmwood Park School District for the current school year.

I acknowledge that participation in athletics involves an inherent potential for injury. Although the staff members exercise every precaution against possible injury, parent or guardians are required to assume responsibility for consenting to participation and to risk the liability of injury. I acknowledge that physical hazards may be encountered in the conduct of activity and in all arrangements incidental thereto.

I hereby authorize the release of my child's pertinent medical information to appropriate professional staff. I give consent and understand that the information may be shared, when necessary, with appropriate professional staff involved in the care of my child.

In the event that my child is injured while participating in athletics, I hereby grant permission for my child to receive treatment by the appropriate medical staff member or at a duly licensed and certified hospital or medical facility. I understand that emergency medical transportation would not take place until a reasonable effort has been made to contact me.

The Elmwood Park Board of Education provides excess coverage insurance for all student athletes. Such excess coverage generally provides for coverage beyond the initial coverage provided by the student's family home, private, or business insurance.

I am advised that student-athletes are held responsible for the athletic equipment and uniforms owned and issued to them by the school district. Also, I am advised that student athletes are to adhere to the Elmwood Park Board of Education Student/Athletic Conduct and Responsibilities Policy.

II. Transfer Students/Foreign Exchange Students

If the athlete attended a high school (9-12th grades) other than Elmwood Park High School in the preceding school year, please list the name of the school, city, and state below:

III. Eligibility

I am advised that in order to participate in games or practices the student must meet all terms of medical and academic eligibility. A completed medical history and physical examination must be completed and which must then be granted final approval by the school physician.

Signature of Parent/Guardian: _____

Date: _____

Signature of Student: _____

Date: _____

ELMWOOD PARK SCHOOL DISTRICT

HEALTH HISTORY UPDATE

Student's Name: _____ DOB: _____

Grade: _____ School Year: _____ Date of last physical: _____

Since the last pre-participation physical examination, has your son/daughter:

Been medically advised not to participate in a sport? YES NO

If YES, please explain: _____

Sustained a concussion, been unconscious or lost memory from a blow to the head? YES NO

If YES, please explain: _____

Broken a bone or sprained/strained/dislocated any muscle or joints? YES NO

If YES, please explain: _____

Fainted or "blacked out?" YES NO

If YES, please explain: _____

Experienced chest pains, shortness of breath or "racing heart?" YES NO

If YES, please explain: _____

Has there been a recent history of fatigue and unusual tiredness? YES NO

If YES, please explain: _____

Been hospitalized or had to go to the emergency room? YES NO

If YES, please explain: _____

Since the last physical examination, has there been a sudden death in the family or has any member of the family under age 50 had a heart attack or "heart trouble?" YES NO

If YES, please explain: _____

Started or stopped taking any over-the-counter or prescribed medications? YES NO

If YES, please explain: _____

Medically excused from physical education for more than 2 days? YES NO

If YES, please explain: _____

Date: _____ Signature of Parent/Guardian: _____

ELMWOOD PARK SCHOOL DISTRICT
MEDICAL TREATMENT CONSENT
EMERGENCY CONTACT FORM

Student Name: _____ Sport/Activity: _____

In the event of a medical emergency, I hereby grant permission for my child to receive emergency medical transportation to and treatment at a duly licensed and certified hospital or medical facility.

Signature of Parent/Legal Guardian

Date

Doctor's Name: _____ Phone Number: _____

Hospital of Preference: _____

EMERGENCY CONTACT INFORMATION

Mother/Guardian's Name: _____

Phone Number(s): _____

Father/Guardian's Name: _____

Phone Number(s): _____

In the event that you cannot be reached, please provide us with a parental substitute:

Parental Substitute Name: _____ Phone Number(s): _____

PLEASE PROVIDE THE FOLLOWING MEDICAL INFORMATION:

1. Does your child have a history of any of the following conditions (please check):

_____ Heart Condition _____ Diabetes _____ Epilepsy _____ Asthma

2. Is your son/daughter currently taking any medication?

_____ YES _____ NO Please List: _____

3. Does your son/daughter have any allergies (food, medication, bee stings, other)?

_____ YES _____ NO Please List: _____