

HIGH SCHOOL ATHLETIC CONSENT FORM

Name: _____ I.D.# _____ / / GR. _____ M/F
Last First Birth Date (In Fall) Circle
Parent /Guardian Name: _____ Hm. Phone: () _____
Last First Wk. Phone: () _____
Cell Phone: () _____
Address: _____

EMERGENCY CONTACT IN THE EVENT PARENT/GUARDIAN CANNOT BE REACHED:

Name: _____ Hm. Phone: () _____
Last First Wk. Phone: () _____
Relationship: Parent Guardian Step Parent Relative Friend Cell Phone: () _____
Name: _____ Hm. Phone: () _____
Last First Wk. Phone: () _____
Relationship: Parent Guardian Step Parent Relative Friend Cell Phone: () _____

PLEASE READ EACH STATEMENT AND SIGN AT THE BOTTOM

I. CONSENT FOR EMERGENCY TREATMENT

Treatment Consent: In the event of an accident or emergency, I (we) give permission for the school authorities to take my (our) child to any doctor or hospital, or request their services. If not, please advise the school as to what action you would like to be taken:

Athletic Trainer Consent: I give my permission to the Athletic Trainer to administer first aid, follow-up treatment and rehabilitation when appropriate in his/her professional judgment, as approved by the consulting physician.

YES OR NO

II. MEDICATION DURING ATHLETICS

My child may need medication during school hours, athletic practices, field trips, or competitions. This may include prescription medication, such as inhalers or EpiPen OR over-the-counter medication such as Advil or Tylenol. I understand that my child's physician and I, as the parent/guardian, need to complete an IUSD Parent/Guardian and Physician Request for Medication form which can be obtained from the school Health Office or www.iusd.org

YES OR NO

III. MUSCULOSKELETAL SCREENING CONSENT

I authorize permission for my child to receive an Athletic Pre-Participation Musculoskeletal Screening at my child's school. **I understand it does not replace the Athletic Pre-Participation Physical Exam by my child's personal Healthcare Provider.**

YES OR NO

IV. INSURANCE CERTIFICATION

I hereby certify that my child is insured for accidental death insurance in the amount of \$1,500 and for at least \$1,500 insurance protection for medical and hospital expenses resulting from accidental bodily injury while participating in inter-school athletic events or while being transported to and from such athletic events.

YES OR NO

Please check one of the following:

____ My child is insured for the above activity under our family Health/Medical Plan.

Name of Company _____

PPO – HMO – KAISER – OTHER (circle one)

____ I have purchased the school insurance plan.

V. TRANSFER ELIGIBILITY

Has student attended ANY other High School? If yes, name of school _____

YES OR NO

VI. COMMUNICATION PROCEDURES

I understand that the orderly use of the following procedures is suggested when offering input to the Athletic Department, and that written documentation is recommended.

1. Discuss needs, complaints or concerns with the Coach.
2. If not satisfied, request a conference with the Athletic Director.
3. If individual conferences with Coach and Athletic Director are not satisfying, then a conference with all parties will be held with the Assistant Principal of Athletics.
4. If the athlete and/or parent(s) are still not satisfied, then an appeal may be made to the Principal.
5. I have read and understand the Athletic Code.

VII. PARENT OR GUARDIAN CONSENT

I hereby give my consent for the above named student to compete in IUSD approved activity programs such as: Sports, Marching Band, Cheerleading Squad, etc. and travel with the school representative on necessary school trips. **I realize that there is a risk of serious injury or death from participating in school sports and related activities.** It is understood that the school district, the student body, and/or any of the employees are not financially responsible in case of accident or injury.

Date: _____

Signature of Parent/Guardian: _____