

# **Benzie Central High School**



## **Athletic Packet**

# Benzie Central Athletics

Dear Parent(s)/Guardian(s) and Athlete,

Welcome to the 2021/22 Benzie Central Sports season! We are delighted that you are joining us and we want to help you be successful in completing the necessary documents for participation. This packet will give you the necessary forms needed by your coach, athletic trainer, school administration and MHSAA. Please make sure that all forms and payment are completed prior to the first day of practice. It is very important that all information is provided. Please notice that many forms, including the Athletic Release form requires both a parent and athlete signature.

Thank you,

Benzie Central Athletic Department

## Important Information

- Sports Physical must be dated by physician on or after April 15, 2021, to be valid for the 2021/22 school year
- Pay to Participate fees (to Athletic Office)
  - HS Participation Fees: \$35/sport or \$100 max/school year
  - MS Participation Fees: \$25/sport or \$70 max/school year
  - Families-MS or HS: \$200 max for the school year
- Athletic Sports Passes
  - Pay one price and get in all year!
    - \$110 -Family
    - \$55 - Adult
    - \$25 - Student

For all questions and payment for both Pay to Participate and Athletic Sports Passes, please see Mrs. Grose in the Athletic Office. All checks can be made payable to Benzie County Central School (BCCS)

**Benzie Central Athletic Department**

**Student Athlete Emergency Information Form**

Parents and/or Guardians:

The following is a permission form that must be completed and signed by you and your student athlete before they may participate in an interscholastic athletic event for Benzie Central Schools. In signing this letter you should be aware of the following important points:

1. Benzie Central Schools **DOES NOT** provide an insurance program covering health or injury problems resulting from athletics. It is the responsibility of the athlete and their family to provide such insurance and to take care of any medical expenses.
2. In signing this form you are giving your student athlete permission to travel under the coach's direction and authority to and from athletic events.
3. The coaches shall have the authority to seek medical attention in case of injury in any athletic gathering (practice, contests or authorized team activity).

Athlete Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Grade: \_\_\_\_\_ Gender: Male Female

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Phone (home/cell): \_\_\_\_\_ Work (mom/dad): \_\_\_\_\_

**IF AN EMERGENCY SHOULD OCCUR AND PARENTS CANNOT BE REACHED, THE FOLLOWING INDIVIDUALS WILL BE CALLED:**

Emergency #1: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency#2: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Hospital Choice: \_\_\_\_\_

In case of an accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated and to follow their instructions. If the physician cannot be reached, the school may make whatever arrangements deemed necessary for the well-being of the child. I understand medical information may be provided to the Athletic Department for my child to participate in interscholastic athletics. This information will be treated with full confidentiality by this department.

Athlete Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICAL HISTORY**

Indicate any issues we need to be aware of for the health and well-being of your student.

ALLERGIES: \_\_\_\_\_ ASTHMA: \_\_\_\_\_

SEIZURES: \_\_\_\_\_ DIABETES: \_\_\_\_\_

CARDIAC: \_\_\_\_\_ SURGERIES: \_\_\_\_\_

CURRENT MEDICATIONS: \_\_\_\_\_

Athletic Release Form

Athlete's Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Sport(s) Participating in this school year: \_\_\_\_\_

Parents/Guardians Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_

Mailing Address (if different): \_\_\_\_\_

Email (parents): \_\_\_\_\_

Email (students): \_\_\_\_\_

By signing this form, you are indicating that you have read, understand and will support the rules, policies and procedures of the Benzie County Central Schools.

You are also acknowledging the fact that you understand athletics have an inherent risk involved while participating in sports. The coaches and staff are trained to maintain your athlete's safety as their most important priority, but you must also remind your athlete they need to follow the directions given by the coaching staff.

Understand at times, the media and other educational institutions request information about your athlete and their athletic activities, you understand we will provide only the following items: name, grade, individual and/or team pictures, game statistics, and annual awards, other information will only be supplied with proper releases from the counseling office and principal's office.

I hereby give my consent for my athlete (name) \_\_\_\_\_ to engage in interscholastic athletics and for the disclosure of the MHSAA of information otherwise protected by FERPA and HIPPA for the purpose of determining eligibility for interscholastic athletics: and I understand the possibility that serious injury may result from participating in athletic activities. My athlete has my permission to accompany the team as a member on its out-of-town trips. I further understand that my son/daughter will be expected to adhere firmly to all established athletic policies of Benzie County Central Schools and the Michigan High School Athletic Association.

\_\_\_\_\_  
Student/athlete Signature

\_\_\_\_\_  
Parent/guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

# PARENT & ATHLETE CONCUSSION INFORMATION SHEET



## WHAT IS A CONCUSSION?

A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by a bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth. Even a “ding,” “getting your bell rung,” or what seems to be a mild bump or blow to the head can be serious.

## WHAT ARE THE SIGNS AND SYMPTOMS OF CONCUSSION?

Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury.

If an athlete reports one or more symptoms of concussion after a bump, blow, or jolt to the head or body, s/he should be kept out of play the day of the injury. The athlete should only return to play with permission from a health care professional experienced in evaluating for concussion.

### DID YOU KNOW?

- Most concussions occur without loss of consciousness.
- Athletes who have, at any point in their lives, had a concussion have an increased risk for another concussion.
- Young children and teens are more likely to get a concussion and take longer to recover than adults.

## SYMPTOMS REPORTED BY ATHLETE:

- Headache or “pressure” in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light
- Sensitivity to noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Just not “feeling right” or is “feeling down”

## SIGNS OBSERVED BY COACHING STAFF:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes
- Can’t recall events prior to hit or fall
- Can’t recall events after hit or fall

[ INSERT YOUR LOGO ]



**“IT’S BETTER TO MISS ONE GAME THAN THE WHOLE SEASON”**

## CONCUSSION DANGER SIGNS

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. An athlete should receive immediate medical attention if after a bump, blow, or jolt to the head or body s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that gets worse
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people or places
- Becomes increasingly confused, restless, or agitated
- Has unusual behavior
- Loses consciousness (even a brief loss of consciousness should be taken seriously)

## WHAT SHOULD YOU DO IF YOU THINK YOUR ATHLETE HAS A CONCUSSION?

1. If you suspect that an athlete has a concussion, remove the athlete from play and seek medical attention. Do not try to judge the severity of the injury yourself. Keep the athlete out of play the day of the injury and until a health care professional, experienced in evaluating for concussion, says s/he is symptom-free and it's OK to return to play.
2. Rest is key to helping an athlete recover from a concussion. Exercising or activities that involve a lot of concentration, such as studying, working on the computer, and playing video games, may cause concussion symptoms to reappear or get worse. After a concussion, returning to sports and school is a gradual process that should be carefully managed and monitored by a health care professional.
3. Remember: Concussions affect people differently. While most athletes with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer.

## WHY SHOULD AN ATHLETE REPORT THEIR SYMPTOMS?

If an athlete has a concussion, his/her brain needs time to heal. While an athlete's brain is still healing, s/he is much more likely to have another concussion. Repeat concussions can increase the time it takes to recover. In rare cases, repeat concussions in young athletes can result in brain swelling or permanent damage to their brain. They can even be fatal.

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STUDENT-ATHLETE NAME PRINTED

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STUDENT-ATHLETE NAME SIGNED

---

DATE

---

PARENT OR GUARDIAN NAME PRINTED

---

PARENT OR GUARDIAN NAME SIGNED

---

DATE

JOIN THE CONVERSATION  [www.facebook.com/CDCHeadsUp](http://www.facebook.com/CDCHeadsUp)



HEADS UP

TO LEARN MORE GO TO >> [WWW.CDC.GOV/CONCUSSION](http://WWW.CDC.GOV/CONCUSSION)

Content Source: CDC's Heads Up Program. Created through a grant to the CDC Foundation from the National Operating Committee on Standards for Athletic Equipment (NOCSAE).

**Concussion Information Sheet for Athletes, Parents or Legal Guardians**

**What is a concussion?** A concussion is an injury to the brain caused by a direct or indirect blow to the head. It results in your brain not working as it should. The concussion may or may not cause you to black out or pass out. It can happen from a fall, a hit to the head, or a hit to the body that causes your head and your brain to move quickly back and forth.

**How do I know if I have a concussion?** There are many signs and symptoms that you may have after a concussion. A concussion can affect your thinking, the way your body feels, your mood, or your sleep. Here is what to look for the following symptoms:

<b>Thinking</b>	<b>Physical</b>	<b>Emotional/Mood</b>	<b>Sleep</b>
<ul style="list-style-type: none"> <li>• Difficulty thinking clearly</li> <li>• Taking longer to figure things out</li> <li>• Difficulty concentrating</li> <li>• Difficulty remembering new information</li> </ul>	<ul style="list-style-type: none"> <li>• Headache</li> <li>• Fuzzy or blurry vision</li> <li>• Feeling sick to your stomach/queasy</li> <li>• Vomiting/throwing up</li> <li>• Dizziness</li> <li>• Balance problems</li> <li>• Sensitivity to noise or light</li> </ul>	<ul style="list-style-type: none"> <li>• Irritability- things bother you more easily</li> <li>• Sadness</li> <li>• Being more moody</li> <li>• Feeling nervous or worried</li> <li>• Crying more</li> </ul>	<ul style="list-style-type: none"> <li>• Sleeping more than usual</li> <li>• Sleeping less than usual</li> <li>• Trouble falling asleep</li> <li>• Feeling tired</li> </ul>

Table is adapted from the Centers for Disease Control and Prevention (<http://cdc.gov/concussions/>).

**What should I do if I think I have a concussion?** If you are having any of the signs and symptoms listed above, you should tell your parents, coach, athletic trainer, or school nurse, so you can get the help you need. If a parent notices these symptoms, he or she should inform the school nurse or athletic trainer.

**When should I be particularly concerned?** If you have a headache that gets worse over time, you are unable to control your body, you throw up repeatedly or feel more and more sick to your stomach, or your words are coming out funny or slurred, let an adult such as your parent, coach, or teacher know right away, so you can get the help you need before things get any worse.

**What are some of the problems that may affect me after a concussion?** You may have trouble in some of your classes at school or even with activities at home. If you continue to play or return to play too early after a concussion, you may have long-term trouble remembering things or paying attention, headaches may last a long time, or personality changes can occur. Once you have a concussion, you are more likely to have another concussion.

**How do I know when it's ok to return to physical activity and my sport after a concussion?** After telling your coach, your parents, and any available medical personnel that you think you have a concussion. According to the Benzie Central and POMH Concussion policy, you must follow the concussion management flow sheet and appropriate return to sport protocol administered by a trained appropriate medical profession (Athletic Trainer or Physical Therapist). Then be referred to a physician to be cleared by them. **You CAN NOT return to play or practice on the same day as your suspected concussion occurred due to MHSAA rules. You must have the official MHSAA unconditional return to sport form in order to return.**

**You should not begin the return-to-play progression, until all symptoms are gone, both at rest and during and after activity, unless allowed to by Certified Athletic Trainer or other trainer**

**professional. Symptoms indicate that your brain has not yet recovered from the concussion and needs more rest.**

*\*If there is anything on this sheet that you do not understand, please ask an adult to explain or read it to you.*

Athlete Name:

*This form must be completed by every athlete, even if there are multiple athletes in the household.*

Parent or Legal Guardian Name(s):

*Review and sign even if athlete is 18 or older*

We have read the "Athlete and Parent or Legal Guardian Concussion Information Sheet  
*If true, please check box*

**Athlete  
Initials**

**Parent or  
legal  
guardian  
Initials**

After reading the information sheet, I am aware of the following information:

A concussion is a brain injury, which should be reported to my parents, my coach(es), or athletic trainer.

A concussion can affect the ability to perform everyday activities such as ability to think, balance, and perform in the classroom.

A concussion cannot be "seen." Some symptoms might be present right away. Other symptoms can show up hours or days after an injury.

I will tell my parents, my coach, or athletic trainer about my injuries and illnesses.

Not Applicable

If I think a teammate has a concussion, I should tell my coach(es), parents or athletic trainer.

Not Applicable

I will not return to play in a game or practice if a hit to my head or body causes any concussion related symptoms.

Not Applicable

I will/my child will need written permission from a medical professional trained in concussion management to return to play or practice after a concussion, an athletic trainer then a doctor.

According to the latest data, most concussions take days or weeks to get better. A concussion may not go away right away. I realize that resolution from this injury is a process and may require more than 1 medical evaluation.

I realize that emergency department or urgent care physicians will not provide clearance if the patient is seen right away after the injury.

After a concussion, the brain needs time to heal. I understand that I am/my child is much more likely to have another concussion or more serious brain injury, even death, if return to play or practice occurs before concussion symptoms go away.

Sometimes, repeat concussions can cause serious and long-lasting problems.

**I have read and understand the concussion symptoms on the Concussion Information Sheet.**

Signature of athlete

Date

Signature of Parent or Legal Guardian

Date



# Consent for Medical Treatment

Benzie Central High School-Athletic Training



I, \_\_\_\_\_, an 18-year old or Parent or legal guardian of \_\_\_\_\_, born \_\_\_\_\_, recognize that as a result of athletic participation, medical treatment on an emergency basis may be necessary, and further recognize that school personnel may be unable to contact me for my consent for emergency medical care. The emergency medical care initially, will be provided by a Certified Athletic Trainer or Board Certified Sports Clinical Specialist in Physical Therapy (SCS). I do hereby consent in advance to such emergency care, including hospital care, as deemed necessary under the then-existing circumstances and to assume the expenses of such care.

Student's Name: \_\_\_\_\_

Gender: \_\_\_\_\_ Grade: \_\_\_\_\_

Emergency Contact 1 Name: \_\_\_\_\_

Cell: \_\_\_\_\_ Work: \_\_\_\_\_ Relation: \_\_\_\_\_

Emergency Contact 2 Name: \_\_\_\_\_

Cell: \_\_\_\_\_ Work: \_\_\_\_\_ Relation: \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent /Guardian or 18 year-old

\_\_\_\_\_  
Date

## AUTHORIZATION TO CONTACT, INTERVIEW, PHOTOGRAPH, RECORD, OR RELEASE PROTECTED HEALTH INFORMATION FOR PROMOTIONAL/EDUCATIONAL PURPOSES

Information about you and your health is personal, and Munson Healthcare is committed to protecting the privacy of that information. When we want to share your information for the public to see or hear, we must ask you for written permission (authorization). You can ask to stop an interview or recording session at any time.

**Please read this form carefully and ask any questions you have before signing it.**

I, (PRINT NAME) \_\_\_\_\_ **authorize Munson Healthcare and/or its affiliates and service organizations to contact, interview, take audio/photography/video of me, and to use and/or share information about me for promotional and/or educational purposes on behalf of Munson Healthcare, including:**

- Advertisements, brochures, electronic communications, multimedia productions, publications, social media, web sites, etc., directed to staff, physicians, volunteers, patients, visitors, and the general public
- Local or national news media coverage

**Information about me to be used and/or shared includes:**

- My appearance/likeness on recorded or electronic media (*e.g. interview notes, audio, photographs, video, etc.*) and information about my diagnosis and treatment gathered through interviews with me by Munson Healthcare staff or the news media
- Information, including Protected Health Information, gathered through interviews with health care providers and others involved in my care (*e.g. physicians, nurses, technicians, staff, etc.*)

I understand that signing or refusing to sign this authorization will not affect the delivery of care in any way.

I understand that this authorization does not include any promise to pay me and that Munson Healthcare will not receive payment of any kind for the use of information/material covered by this authorization.

I understand that information/material covered by this authorization may be used at any time, with no expiration date.

After signing this authorization, I understand I may change my mind and revoke this authorization in writing, except to the extent of action already taken based on this authorization. Once information/material is used and/or shared as allowed by this authorization, it is no longer protected under federal and state privacy laws and may be subject to re-disclosure.

I release and forever discharge Munson Healthcare and its agents, from any claims and demands in connection with the use of information/material covered by this authorization, including, but not limited to, any claims for invasion of privacy or defamation.

SIGNATURE (INDIVIDUAL OR RESPONSIBLE REPRESENTATIVE): \_\_\_\_\_

NAME OF RESPONSIBLE REPRESENTATIVE (if applicable): \_\_\_\_\_ RELATIONSHIP TO INDIVIDUAL: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

SIGNATURE (WITNESS/ORG. REPRESENTATIVE): \_\_\_\_\_

NAME (WITNESS/ORG. REPRESENTATIVE): \_\_\_\_\_ DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

**INTERNAL USE:**

TOPIC: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**ORGANIZATION:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Kalkaska Memorial Health Center       | <input type="checkbox"/> Munson Healthcare Grayling Hospital | <input type="checkbox"/> Munson Medical Center                |
| <input type="checkbox"/> Mackinac Straits Health System        | <input type="checkbox"/> Munson Healthcare Home Health       | <input type="checkbox"/> North Flight EMS                     |
| <input type="checkbox"/> Munson Healthcare Cadillac Hospital   | <input type="checkbox"/> Munson Healthcare Manistee Hospital | <input type="checkbox"/> Otsego Memorial Hospital             |
| <input type="checkbox"/> Munson Healthcare Charlevoix Hospital | <input type="checkbox"/> Paul Oliver Memorial Hospital       | <input type="checkbox"/> Other MHC Affiliate (Please Specify) |



MEDICAL HISTORY: Completed by Parent or Guardian or 18-Year-Old

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Doctor: \_\_\_\_\_ Doctor's Phone: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

GENERAL QUESTIONS, HEART HEALTH QUESTIONS ABOUT YOU, HEART HEALTH QUESTIONS ABOUT YOUR FAMILY, BONE AND JOINT QUESTIONS

MEDICAL QUESTIONS, FEMALE ONLY (Optional), CURRENT-YEAR PHYSICAL = GIVEN ON OR AFTER APRIL 15 OF THE PREVIOUS SCHOOL YEAR

PHYSICAL EXAMINATION & MEDICAL CLEARANCE: Completed by MD, DO, PA or NP - RETURN DIRECTLY TO PATIENT

EXAMINATION: Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Male Female BP: / Pulse: Vision: R 20/ L 20/ Corrected: Y N

Table with columns: MEDICAL, NORMAL, ABNORMAL, MUSCULOSKELETAL, NORMAL, ABNORMAL. Rows include Appearance, Eyes/Ears/Nose/Throat, Heart, Lungs, Abdomen, Genitourinary, Skin, Neurologic.

RECOMMENDATIONS:

I certify that I have examined the above student and recommend him/her as being able to compete in supervised athletic activities NOT crossed out below. BASEBALL - BASKETBALL - BOWLING - COMPETITIVE CHEER - CROSS COUNTRY - FOOTBALL - GOLF - GYMNASTICS - ICE HOCKEY LACROSSE - SKIING - SOCCER - SOFTBALL - SWIMMING/DIVING - TENNIS - TRACK & FIELD - VOLLEYBALL - WRESTLING

EXAMINER Name of Examiner (print/type): \_\_\_\_\_ Date: \_\_\_\_\_ Signature of Examiner: \_\_\_\_\_ (Check One): MD DO PA NP

(DETACH HERE IF NEEDED TO ACCOMPANY STUDENT-ATHLETE)

EMERGENCY INFORMATION: COMPLETED BY PARENT or GUARDIAN or 18-YEAR-OLD

Student: \_\_\_\_\_ Grade: \_\_\_\_\_ Doctor: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ IN EMERGENCY (1): \_\_\_\_\_ Home #: (\_\_\_\_) \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_ IN EMERGENCY (2): \_\_\_\_\_ Home #: (\_\_\_\_) \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_ Drug Reactions: \_\_\_\_\_ Current Medications: \_\_\_\_\_ Allergies: \_\_\_\_\_



PRE-PARTICIPATION PHYSICAL - CONSENT - INSURANCE

Shaded headline areas are to be completed by student, parent/guardian or 18-year-old

There are FOUR (4) signatures on this page 4 to be completed by student, parent/guardian and/or 18-year-old

A CURRENT-YEAR PHYSICAL IS ONE GIVEN ON OR AFTER APRIL 15 OF THE PREVIOUS SCHOOL YEAR

Student Name: LAST FIRST MIDDLE INITIAL
Student Address: STREET CITY ZIP
Gender: M F Age: Date of Birth: Place of Birth (City/State):
School: Circle Grade: 6 7 8 9 10 11 12
Father/Guardian Name:
Phone (home): (work): (cell):
Mother/Guardian Name:
Phone (home): (work): (cell):
Email Address: Parent/Guardian/18-Year-Old:

STUDENT PARTICIPATION & PARENT or GUARDIAN or 18-YEAR-OLD CONSENT

The information submitted herein is truthful to the best of my knowledge. By my/my child's signature below, I/we acknowledge that I/we have received concussion educational information that meets Michigan Department of Health and Human Services and MHSAA requirements.

Further, in consideration of my/my child's participation in MHSAA-sponsored athletics, I/we do hereby agree, understand, appreciate, and acknowledge: that participation in such athletics is purely voluntary; that such activities involve physical exertion and contact and that there is inherent risk of personal injury associated with participation in such activities, which risk I/we assume; and that I/we agree to, and hereby waive any and all claims, suits, losses, actions, or causes of action against the MHSAA, its members, officers, representatives, committee members, employees, agents, attorneys, insurers, volunteers, and affiliates based on any injury to me, my child, or any person, whether because of inherent risk, accident, negligence, or otherwise, during or arising in any way from my/my child's participation in an MHSAA-sponsored sport.

I/we understand that I am/we are expected to adhere firmly to all established athletic policies of my school district and the MHSAA. I/we hereby give my consent for the above student to engage in interscholastic athletics and for the disclosure to the MHSAA of information otherwise protected by FERPA and HIPAA for the purpose of determining eligibility for interscholastic athletics. My child has my permission to accompany the team as a member on its out-of-town trips.

1 Signature of STUDENT: Date:

2 Signature of PARENT or GUARDIAN or 18-YEAR-OLD: Date:

INSURANCE STATEMENT

Our son/daughter will comply with the specific insurance regulations of the school district.

The student-athlete has health insurance: YES NO

If YES, Family Insurance Co: Insurance ID #:

Additionally, I hereby state that, to the best of my knowledge, my answers to the medical history questions (see reverse) are complete and correct.

3 Signature of PARENT or GUARDIAN or 18-YEAR-OLD: Date:

(DETACH HERE IF NEEDED TO ACCOMPANY STUDENT-ATHLETE)

MEDICAL TREATMENT CONSENT: COMPLETED BY PARENT or GUARDIAN or 18-YEAR-OLD

I, an 18-year-old, or the parent or guardian of, recognize that as a result of athletic participation, medical treatment on an emergency basis may be necessary, and further recognize that school personnel may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the then-existing circumstances and to assume the expenses of such care.

4 Signature of PARENT or GUARDIAN or 18-YEAR-OLD: Date: