HIGH SCHOOL INTERSCHOOL ATHLETIC PARTICIPATION FORM

This form is to be completed on behalf of a student who wishes to participate in interschool sports and returned to the coach prior to the student's first practice.

STUDENT NAME _____ SCHOOL _____

HOME ADDRESS _____ POSTAL CODE _____

HOME PHONE # _____ HEALTH CARD NO. _____

PARENT/GUARDIAN _____ WORK PHONE # _____

STUDENT'S PHYSICIAN _____ PHONE # _____

EMERGENCY CONTACT NAME _____ PHONE # _____

MEDICAL INFORMATION **NOTE: As annual medical examination is recommended**

1. Date of last complete medical examination _____
2. Date of last tetanus immunization _____
3. Is your son/daughter/ward allergic to any drugs, foods or medication/other? Yes _____ No _____ If yes, provide details _____
4. Does your son/daughter/ward take any prescription drugs? Yes _____ No _____ If yes, provide details _____
5. Is there already a student Care Plan registered with the school Yes _____ No _____
6. What medication(s) should the participant have on hand during the sport activity? _____
   Who should administer the medication? _____
7. Does your son/daughter/ward wear a medical-alert bracelet? _____. Neck chain? _____ or carry a medical-alert card? Yes _____
8. Does your son/daughter/ward wear eyeglasses? Yes _____ No _____ Contact lenses? Yes _____ No _____
9. Please indicate if your son/daughter/ward has been subject to any of the following and provide pertinent details:
   Epilepsy, diabetes, orthopedic problems, deaf, hard of hearing, asthma, allergies _____
   Head or back conditions or injuries (in the past two years) _____
   Arthritis or rheumatism, chronic nosebleeds, dizziness, fainting, headaches, hernia, swollen or hyper mobile joints, trick or lock knee _____
   Any other medical information that will limit participation? _____
10. Should your son/daughter/ward sustain an injury or contact an illness requiring medical attention during the competitive season, notify the coach and complete the "Request to Resume Athletic Participation Form", if applicable.

MEDICAL SERVICES AUTHORIZATION (Optional)

In case of emergency medical or hospital services being required by the above listed participant, and with the understanding that every reasonable effort will be made by the school/hospital to contact me, my signature on this form authorizes medical personnel and/or hospital to administer medical and/or surgical services including anesthesia and drugs. I understand that any cost will be my responsibility.

SIGNATURE OF PARENT/GUARDIAN _____ **DATE:** _____