CARTHAGE HIGH/MIDDLE SCHOOL

Consent Form for Athletic Participation

Student Name _____ Date of Birth _____ Age ____ Grade_____

Address _____ Phone _____

Sport/Activity _____ Varsity _____ JV_____ Modified _____

Date of last medical exam _____ Provider _____

*** Please explain all "yes" answers below**

		Circle One	
1.	**Since your last medical exam**: any injuries requiring medical attention?	Yes	No
2.	**Since your last medical exam**: any operations or fractures?	Yes	No
3.	**Since your last medical exam**: treated in a hospital or emergency room?	Yes	No
4.	**Since your last medical exam**: Any illness lasting more than five (5) day?	Yes	No
5.	Any feeling of faintness or dizziness during heavy exertion or exercise?	Yes	No
6.	Any family history of sudden death before the age of 50, heart related/unknown cause?	Yes	No
7.	Missing one of a paired organ? (eye, kidney, etc.)	Yes	No
8.	Wear glasses or contact lenses?	Yes	No

Please explain any "yes" answers here: _____

_____

Does your child have a life threatening ALLERGY? Please list type and reaction below. Do any require the use of an Epipen? ☐ Yes ☐ No

☐ Medication: _____ ☐ Food: _____ ☐ Other: _____

CHECK ALL THAT APPLY TO YOUR CHILD:

☐ ADHD ☐ Asthma/trouble breathing ☐ Autism/Asperger ☐ Dental Injuries ☐ Diabetes ☐ Hearing Condition:_____ ☐ Vision Condition: _____	☐ GI Conditions (ulcer, reflux, IBS) ☐ Headaches/migraines ☐ Heart Conditions ☐ High Blood Pressure ☐ Mental Health Condition(circle) (depression, eating disorder, anxiety, OCD, ODD, etc.)_____	☐ Seizures ☐ Single Organ (☐kidney, ☐testicle) ☐ Skin Condition_____ ☐ Speech Condition_____ ☐ Urinary Condition_____ ☐ Vision/Hearing Condition:_____ ☐ Other:_____

PLEASE LIST ALL MEDICATIONS YOUR CHILD IS TAKING: A **school medication order** signed by a NYS licensed provider and **parent permission** is required to be on file with the school nurse for all medications to be administered or carried during school sponsored athletics. Medications must be in **original pharmacy labeled containers**.

Medication Name	Dose (mg, units)	Route (Oral,Inject)	Frequency (Times taken)	Purpose (Asthma, Diabetes, etc.)	Required during sports:	Order Provided to School:
					☐Yes ☐No	☐Yes ☐No
					☐Yes ☐No	☐Yes ☐No
					☐Yes ☐No	☐Yes ☐No

We understand clearly that the questions are asked in order to decide of this student is in a proper condition to participate in the athletic activity named on this form. The answers are correct as of the date this form is signed.

No amount of instruction, precaution or supervision will totally eliminate all risk of injury. Just as in non-school activities, athletic participation by students also may be inherently dangerous. Students and parents must assess the risks involved in such participation. Each makes his/her choice to participate or to allow the child to participate despite the risks. The obligation of parents and students in making this choice cannot be overstated. In granting permission for your child to participate in athletic competition, you, the parent, acknowledge and assume such risks.

Severe head or neck injury, including concussion, paralysis or death may occur despite using a helmet provided your child. No helmet can prevent all head injuries or any neck injuries a player might receive while participating in contact or collision sports/activities.

I have read and understand the concussion information provided to me and have reviewed the information with my child.

I, the parent/guardian of the above student hereby give my consent for him/her to participate in the above activity. I have read and understand the content of this permission form. I am aware that the participation in the above activity is voluntary. I have also reviewed the student/athletic behavior code with my son/daughter and we both understand the basic responsibilities involved within the athletic program. All medical bills are the responsibility of the parents.

Parent/Guardian Signature_____ **Date** _____

Student/Athlete Signature _____**Date** _____

Reviewed: ☐

REVISED 6/2016