



## EPPING HIGH SCHOOL ATHLETIC DEPARTMENT

### **ACKNOWLEDGMENT OF WARNING AND CONSENT AGREEMENT**

I/we, \_\_\_\_\_ am/are the parent(s) or guardian(s) of \_\_\_\_\_ (minor), who desires to participate in the following school sports for the 2010-2011 season: Fall \_\_\_\_\_ Winter \_\_\_\_\_ Spring \_\_\_\_\_

I/we acknowledge that I/we have been informed as to the nature of the sport, and that this sport/extracurricular activity, and that this sport/extracurricular activity may have risks of injury associated for those who participate, including transportation from and to the school campus. Although the school staff will endeavor to provide each participant with due care, the school cannot ensure that my/our child will remain free of injury.

I/we represent that my/our child is physically fit to participate in this sport/extracurricular activity and, if required, that he/she has been examined by a licensed physician who verifies that my/our child is physically fit to participate in this particular sport/extracurricular activity. The school district will rely on this representation. I/we understand that if my/our child has a serious injury or illness that he/she will need to be reexamined by a licensed physician to verify that my/our child is physically fit to participate in this particular sport/extracurricular activity after injury/illness.

I/we understand that school cannot ensure safety for children and that the school's obligation is to take reasonable precautions for safety and well-being. My/our child also has a responsibility for his/her own safety and that of others.

I/we acknowledge that I/we must provide the athletic/extracurricular staff with any medical or other information which I/we feel is important for the school to know about my/our son/daughter. This information must be kept confidential. I/we will provide medical and other information on my/our child prior to the start of the first practice or extracurricular activity. The School District will rely on me/us to provide this additional information.

I/we acknowledge my/our child must adhere to all policies, procedures, rules, regulations and instructions pertaining to school athletics or extracurricular activities, and that failure to comply could exclude my/our child from participation in this sport or extracurricular activity. Students shall not use, have in their possession, or be in the presence of underage/illegal substances including, but not limited to, illegal drugs, alcohol, tobacco, inhalants, and medications contrary to the manner for which they were prescribed. This policy applies to all participants and applies on or off school grounds, 24 hours a day.

I/we acknowledge receipt of the Athletic Code of Conduct and will adhere to this policy if applicable.

I/we acknowledge and understand the risks and requirements for my/our child to participate in the sport/extracurricular activity of \_\_\_\_\_. I/we consent to my/our child's participation in this sport/activity.

I/we understand that prior to my/our child's participation in this sport; I/we must provide the school nurse with the following documentation:

- Up to date immunization records (tetanus shots are good for up to 10 years, unless there has been serious injury).
- A copy of a physical examination – **signed, dated and office stamped by a medical provider** – with the provider stating the athlete is '**physically fit and able to participate in school sponsored sports.**'
  - Physical examinations are good for two years from the date of the last physical. **Example** – a physical done on 9/01/2004 will be good through 9/01/2006.
- Health insurance company name and ID number. **Confidential** information on free or reduced-cost health care and insurance is available by called the Heath Office during school hours (7:25am-2:25pm) at 603.679.5472 x214 or x242. School insurance is also available, costing under \$20 for a school year.

In order to insure all athletes health and safety during his/her athletic experience, the above medical records, this

Acknowledgment of Warning and Consent Agreement and the Health Information Sheet are due to the school nurse **two weeks before the last day of school for fall sports or, at least two school days prior to the first practice for all others.**

- 1) Please read entire form. If there is anything about this form or the described activity that you do not understand, do not sign the form until you are satisfied that you have obtained a complete explanation.
- 2) Fill in ALL blanks.
- 3) If you have more than one child participating, complete one form per child.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Parent/Guardian Signature Date

**TO BE COMPLETED BY A PARENT/GUARDIAN:**

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_  
Home Address: \_\_\_\_\_ Town: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**EMERGENCY CONTACTS:** (MUST have 'Other Contact' listed, in the event that you cannot be reached during a medical emergency)

Mother/Guardian: \_\_\_\_\_  
Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
Father/Guardian: \_\_\_\_\_  
Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
Other Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_  
Family Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

**GENERAL INFORMATION:** (Please complete ALL lines)

Food or drug allergies: \_\_\_\_\_  
Other allergies: \_\_\_\_\_  
Present medications: \_\_\_\_\_  
Chronic medical problems: \_\_\_\_\_  
Other items of concern: \_\_\_\_\_

**NAME OF HEALTH INSURANCE COMPANY:**

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ ID# \_\_\_\_\_

'I give permission for my student to use insect repellent containing 25% Deet.'  Yes or  No

**PARENTAL AUTHORIZATION:**

'In case of a medical emergency and in the event that I cannot be reached, I authorize the Epping Middle and High Schools, its agents, employees and other officers to procure and consent to any medical examination, diagnostic process or course of treatments ~ including hospital care ~ to be rendered to my child by or under the supervision of any licensed doctor/surgeon, dentist or other health care practitioner.'

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Parent/Guardian Signature Date

**TO BE COMPLETED BY HEALTH OFFICE:**

Date of last physical exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Other concerns: \_\_\_\_\_  
OK to use insect repellent:  Yes or  No \_\_\_\_\_