NISKAYUNA CENTRAL SCHOOLS ATHLETIC CARD

_____M____F_____

Athlete: Last Name First Name Gender

E-Mail Address: _____

Mailing Address: _____

_____

Sport Level Year of Grad. Date of birth

Parent/Guardian Name: _____

Phone: Home_____ Cell_____ Work_____

Other Parent/Guardian Name: _____

Phone: Home_____Cell_____Work_____

If in Middle School ____Iroquois ____Van Antwerp

Please check ____ 7th grade ____8th grade

The student & parent have read the Parent/Athlete handbook and understand the guidelines, procedures, conduct, training rules and consequences. (Athletic Handbook available on District Web Page)

I, the parent/ guardian understand that participating in athletic activities implies risk of injury. I give my son/daughter) _____permission to participate. I have read and reviewed the rules and regulations with my son/daughter.

_____ _____

Parent/Guardian Signature Date

I, the student agree to comply with the terms and conditions set forth in order that I may participate.

_____ _____

Athlete Signature Date

The student has met the physical examination requirements and is eligible to participate.

SCHOOL NURSE AUTHORIZATION: _____

Please note: the school district is not responsible for contact lenses/glasses that are displaced or damaged.

INTERIM HEALTH INFORMATION

Since your last physical for sports participation, have you had any serious illness or injury including a concussion? If yes, diagnosis of illness or injury:	YES	NO
Was hospitalization (including Emergency Room Evaluation) required?	YES	NO
If surgery was required, please specify		
If yes to any of the above, do you have written clearance to resume ALL Physical Education?	YES	NO
Since your last physical for sports participation, have you been diagnosed with ANY Cardiac Problem including High Blood Pressure?	YES	NO
If yes, what treatment has been prescribed?		
Do you have a history of Stinging Insect or Food Allergies?	YES	NO
Do you carry an Epi-Pen?	YES	NO
Do you have Asthma?	YES	NO
Do you carry an Inhaler?	YES	NO
Are you presently taking ANY Medications?	YES	NO
If yes, name of medication and dosage?		

If you have had any serious illness or injury since your last physical for sports participation, WRITTEN clearance from the attending physician is required before the school nurse will authorize your participation in any sport.

EMERGENCY MEDICAL AUTHORIZATION

Purpose: To enable parents and guardians to authorize emergency treatment for children who become ill or injured while under school supervision, when parents or guardians cannot be reached.

Family Physican:_____Phone:_____
Family Dentist:_____Phone:_____

CONSENT OF PARENT OR GUARDIAN FOR EMERGENCY TREATMENT: in the event that reasonable attempts to contact me have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by the above listed doctors or, in the event the designated preferred doctor is not available, by another licensed physician or dentist and be transferred to: _____ or any hospital reasonably accessible.
Initials: _____

THIS AUTHORIZATION DOES NOT COVER MAJOR SURGERY UNLESS THE MEDICAL OPIONIONS OF TWO LICENSED PHYSICIANS OR DENTISTS, CONCURRING IN THE NECESSITY FOR SUCH SURGERY ARE OBTAINED PRIOR TO THE PERFORMANCE OF SUCH SURGERY. THIS AUTHORIZATION ALLOWS RELEASE OF PERTINENT MEDICAL INFORMATION TO COACHES AND ATHLETIC TRAINERS.
Initials: _____

PARENT SIGNATURE_____ DATE_____