HYDE PARK CENTRAL SCHOOL DISTRICT

INTERSCHOLASTIC ATHLETICS EMERGENCY INFORMATION

To be completed by Parent/Guardian – Please use ink, press firmly, print clearly

Student Name _____ Age _____ Date of Birth ____ /____ /____

Last *First* *MI*

Home address _____ Grade _____ **M / F**

_____ Home Phone # _____

Mother's Name _____ Best Contact # _____

Father's Name _____ Best Contact # _____

Emergency Contact _____ Telephone # _____

Physician _____ Telephone # _____

PARENT/GUARDIAN: In accordance with the rules of the Hyde Park Central School District and the New York State Education Department, I hereby give consent for my daughter/son to participate in the interscholastic sport as indicated below.

SPORT
1st CHOICE _____ **2nd CHOICE** _____

PARENT/STUDENT ATHLETE AGREEMENT & PERMISSION TO TREAT

I hereby certify that our daughter/son is a bona fide student in the Hyde Park Central School District and that all information provided is correct. We the undersigned, have read, understand and agree to abide by the policies and procedures contained in the Hyde Park Central School District Student Athlete Handbook; including the NYS mandated concussion policy and the Hyde Park Athletic Department Codes and Policies. To the best of our knowledge, there is no physical condition that would prevent our daughter's/son's participation. In the event that I cannot be reached in an emergency, I hereby give my permission to Hyde Park Central School District personnel to authorize treatment for my daughter/son. I give my permission to permit my daughter/son to be photographed or video recorded as part of the Hyde Park Central School District Athletic Program and to display on the web, television or videos and in media print authorized by the Hyde Park Central School District.

X _____ X _____

Signature of Parent/Guardian *Date* *Signature of Student-Athlete* *Date*

DISTRICT USE ONLY
To be completed by the school nurse

MEDICAL CLEARANCE CARD

Current Physical Exam Date _____ Interval Health History _____ Parent/Guardian Permission _____

ALLERGY _____ ASTHMA _____

EPI-PEN _____ INHALER _____

RESTRICTIONS/MEDICAL CONDITIONS: _____

_____

SPORT RESTRICTIONS: _____

_____

_____ _____

Signature of School Nurse Date

FINAL APPROVAL – STUDENT APPROVED FOR PARTICIPATION _____ **A.D. INITIALS**

Updated June 2016