PLEASE COMPLETE AND RETURN THIS PAGE TO THE ATHLETIC OFFICE

_____ _____ _____
Student: Last Name, First Name, Middle Name Date of Birth Male/Female

Parent's email address _____

Marital Status of parents: _____ Married _____ Divorced _____ Separated _____Single

If divorced or separated, who is the custodial parent:

_____ Mother _____ Father _____ Joint

_____
Person with whom the student is living: Last Name, First Name

_____
Address (street, city, zip) Phone # Relationship

Student anticipates trying out for the following athletic teams:

Fall _____Winter _____Spring _____

CHECK ONE

_____ I/we consent to the release of the following medical information facts concerning our/my child's medical history including allergies, medical diagnosis, physical impairments, and medication being taken at school or at home, to school staff and emergency medical staff for the care and safety of my child.

_____ I/we do not give consent for emergency medical treatment of my child. In the event of illness or injury requiring Emergency treatment, I wish the school authorities take no action or to _____

MEDICATION
School representative may administer the following ANALGESIC and/or BEE STING MEDICATION:

YES	NO	
_____	_____	Aspirin / Acetaminophen (Tylenol or generic) / Ibuprofen (Advil, Nuprin, Motrin or generic)
_____	_____	Diphenhydramine HCCI/Benadryl by mouth if stung by a bee or wasp
_____	_____	EpiPen
_____	_____	Asthma Inhaler (administered if student has own prescription)