

**ST. CHARLES EAST HIGH SCHOOL
2009-10 PARENT PERMISSION FORM**

RETURN FORM TO YOUR COACH BEFORE TRYOUTS!

(BOTH SIDES OF THIS FORM MUST BE FILLED OUT PRIOR TO TRYOUTS OR PRACTICE)

As a parent/guardian, I understand St. Charles East High School will provide safe equipment for use and coaches will follow sound teaching procedures in all activities. Because of the dangers of participating in sports, I recognize the importance of following coaches' instructions regarding playing techniques, training and other teamrules, etc., and agree to obey such instructions. Your signature indicates you understand that through participation in a sport, you are willing to risk the possibility of serious injury and accept that risk. To date there are no proven cases of HIV or Hepatitis B transmission through athletic competition. The theoretical risk is extremely low and does not justify exclusion of HIV/Hepatitis B positive athletes from athletics. I understand that some competitors may be HIV Hepatitis B positive and that I risk a theoretical possibility of exposure to HIV/Hepatitis B infection if he/she is exposed to blood in practice and/or competition. My son/daughter has a current physical and will pay the one time fee before competition starts. My son/daughter will be responsible for the return of all equipment issued. He/she will be charged for any loss of issued equipment.

Sport: _____ **Have you attended any other high school?**

Yes _____ **No** _____ *If yes From:* _____ *Day* _____ *Month* _____ *Yr:* _____ *To:* _____ *Day* _____ *Month* _____ *Yr.*

Student Name: _____ **I.D. #** _____

Address: _____ **City:** _____ **ZIP:** _____

Phone: _____ **Date of Birth** _____ - _____ - _____

Parent Signature _____

AUTHORIZATION FOR MEDICAL TREATMENT

I give my consent/permission to any supervising coach of any sport in which my child is participating in at St. Charles East High School, and the right, on my behalf and in my stand, to arrange for a licensed and certified physicians and/or trainers to render and provide immediate treatment to my child as to injuries that may be sustained by my child while participating in such sport; whether directly or indirectly, and whether sustained during practice or in active inter-scholastic competition, where such injuries consist of, but are not limited to, strains, minor fractures, dislocations, lacerations, contusions, abrasions, and similar injuries and all without necessity of any further or additional express authorization by me other than for this authorization. My above permission and consent also extends to the right of any such supervising coach or school personnel to arrange for immediate medical treatment by a licensed or certified physician and/or trainer, and for them to apply such emergency techniques as may be necessary to my child where the same, in their judgement, is deemed appropriate by reason of any injury sustained by my child, and where the same, in their judgement, is deemed reasonably necessary to preserve the life or limb of my child.

NAME OF CHILD TO WHOM THIS AUTHORIZATION EXTENDS: _____

PARENT GUARDIAN SIGNATURE _____ **DATE** _____

**INSURANCE FORM – 2009-10
ST. CHARLES EAST HIGH SCHOOL**

I understand that St. Charles East High School assumes NO responsibility for the injury of students, however, it is the policy of St. Charles East High School that athletes MUST either purchase school accident insurance (available in the main office) or provide for coverage for personal injury through an individual accident police.

PLEASE CHECK ONE:

_____ **I will purchase school insurance (must be purchased before practice begins)**

_____ **I have my daughter/son included in a family, or personal insurance policy, and therefore, will be responsible for all medical payments either personally or through my insurance policy.**

Parent/Guardian Signature _____ **Date** _____

**ST. CHARLES EAST HIGH SCHOOL
ATHLETIC TRAINER'S INFORMATION CARD**

Name: _____ ID#: _____ Yr. in School: _____

Current Sport: _____ Date of Birth: ___ ___ ___ Current Age: _____

Home Phone No: _____ Home Address: _____

Father's Name & Work No. & Cell No. _____

Mother's Name & Work No. & Cell No. _____

Emergency Name & Number if parent(s) is not available: _____

Physicians Name: _____ Phone No: _____

Wears Contact: _____ : Current Medication being taken: _____

Reason: _____ Allergies: Medication, Insects Bites, etc.,

Previous Injuries (Fractures, Dislocations, etc.)

Any other important information that may be needed if any treatment is required:
