

Grace Brethren Christian School
13000 Zekiah Drive
Waldorf, MD 20601
Phone: 301-645-0406; Fax: 301-645-7463

ATHLETIC PARTICIPATION FORM

This form must be completed each year before any students in grades 6th- 12th may participate in the interscholastic sports program in any manner. The student must have a physical examination by a licensed physician or nurse practitioner, and **the examining physician must then give approval in writing by filling out the physician's portion of this form.** Please note that **a parent will also need to sign this form in multiple places.** This form must be returned to the particular coach or Athletic Director before the student is permitted to try out for any sports team.

STUDENT'S NAME: _____ SPORT(S): _____

STUDENT'S BIRTHDATE: _____ AGE: _____ GRADE: _____

PARENT'S/GUARDIAN'S NAME: _____

PARENT'S ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

MOTHER'S HOME PHONE: _____ FATHER'S HOME PHONE: _____

WORK PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ CELL PHONE: _____

E-MAIL ADDRESS: _____ E-MAIL ADDRESS: _____

A. PARENTAL PERMISSION AND LIABILITY WAIVER

I give my child (named above) permission to participate in the interscholastic school athletic program at Grace Brethren Christian School including practices, games, and all travel involved. Due to our very busy athletics schedule, it may occasionally be necessary to transport your child to an away athletics event via personal vehicle. These vehicles are driven by school staff members, parents or coaches. Please check one of the following:

- Yes, my child has my permission to travel to athletics events via personal vehicle as needed.
- No, my child does not have permission to travel to athletics events via personal vehicle. Please contact me to make arrangements for me to transport my child when a school bus is not available.
- My child is a driver and may drive himself/herself to away athletic events. I understand that no one else will be riding with my child.

I understand that there are inherent dangers, including possible bodily injury, which may result from participation in athletic activities. I will not hold the coaches, other school personnel, or the school liable or responsible in the event of an injury. In the event of an emergency occurring while my son/daughter is participating in a school-sponsored practice, performance or trip, I grant permission for the school and its employees to take whatever action is necessary. In the event that I cannot be reached, I hereby authorize the school and/or its employees to give consent for my son/daughter to receive medical treatment.

I understand that the school has no funds to meet the bills resulting from necessary care of pupils in emergencies. I will be responsible for any costs which may be incurred as a result of illness and/or injuries sustained by my child. The school does, however, maintain supplemental accident insurance coverage for students participating in school activities, both on and off campus. Claims are to be made with my insurance company first, and then directly with the company that provides the supplemental insurance. I am aware that I can contact the school office for information on how to file a claim.

I understand that my child is responsible for compliance with the coach and to school policies in all matters.

I certify that to the best of my knowledge my child has no physical impairment which could be a danger for him/her.

I agree to all of the above.

Parent's Signature

Date

B. HEALTH AND EMERGENCY INFORMATION

Does your child have any medical or physical conditions that the coaching staff should be informed of (i.e., heart problems, allergies to medications or insect stings, kidney problems, asthma, etc.)? Please specify:

CHILD'S PHYSICIAN: _____ PHONE: _____

HEALTH INSURANCE CO.: _____ PHONE: _____

SUBSCRIBER'S NAME: _____ INSURED'S ID/POLICY NO.: _____

In the event that parents/guardians cannot be reached, please specify other persons you wish to give permission to act on your behalf for your child:

NAME: _____ PHONE: _____

NAME: _____ PHONE: _____

In the event of an emergency requiring medical attention, I hereby grant permission to a physician or other hospital personnel designated by the GBCS staff to attend to my son/daughter. _____ **(Parent's initials)**

Permission is also granted to the Coaching Staff to administer first aid for cuts, bruises, and other health issues resulting from sports participation according to normal health practices, as well as to oversee my child's athletic conditioning/training program.

I expect that every effort will be made to contact me in order to receive my specific authorization before any physician's treatment or hospitalization is undertaken.

I agree to all of the above.

Parent's Signature

Date

PHYSICAL EXAMINATION PORTION (BELOW) TO BE COMPLETED BY A PHYSICIAN

Date of Physical: _____

Heart Condition or Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Asthma	<input type="checkbox"/> YES <input type="checkbox"/> NO
Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Allergic to Medication	<input type="checkbox"/> YES <input type="checkbox"/> NO
Convulsive Disorder	<input type="checkbox"/> YES <input type="checkbox"/> NO	Allergic to Insect Stings	<input type="checkbox"/> YES <input type="checkbox"/> NO

Allergies: _____

Date of Last Tetanus Shot: _____

Special Medication Taken on a Regular Basis: _____

Physical Impairments/Limitations: _____

General Health: _____

Additional information that may be helpful: _____

Doctor's Name (print): _____ Doctor's Office Phone #: _____

Doctor's Signature: _____

Doctor's Office Address: _____