

Student Name: _____

Activity	Date(s)	Location

PLEASE NOTE:

- Sign below to indicate that your son/daughter will be attending the above activities.
- Due to inclement weather, and/or sites becoming available, alternative activities may be substituted for the above noted activity.

PARENTAL PERMISSION:

I give _____ my permission to attend the above activities. I understand that transportation will be by school vans and I consent to this. I also understand and agree that my child must wear a seatbelt when traveling in a vehicle.

I give _____ permission to attend activities within walking distance of the school that are not listed above. I also give the supervisor permission to seek medical help if my child requires it.

Emergency contact person: _____

Emergency telephone number: _____

Signature of Parent/Guardian

Date

Medical Release Form

Students registered in Physical Education/Hockey Academy at Catholic Central High School are offered a wide range of varied activities. Sometimes students have medical histories or handicaps, which impair their full and unhindered participation in an activity. Consequently, the students must be provided with adaptive and/or alternative programs. Should your son/daughter have any such difficulty, please describe the problem on the attached document. Please understand that this information is for the protection and benefit of your son/daughter. All information is confidential.

Alta. Health Care Number: _____

Name: _____ Grade: _____ Quarter: _____

Address: _____

Name of Mother/Guardian: _____

Cell Phone: _____ Home Phone: _____

Name of Father/Guardian: _____

Cell Phone: _____ Home Phone: _____

Family Physician: _____ Phone: _____

Clinic: _____ Phone: _____

Family Contact Person: _____ Phone: _____

Please indicate (check box) if your son/daughter has been subject to any of the following:

<input type="checkbox"/> Epilepsy <input type="checkbox"/> Diabetes <input type="checkbox"/> Orthopedic problems <input type="checkbox"/> Cardiovascular conditions <input type="checkbox"/> Head or back conditions or injuries (in the past 2 years)	<input type="checkbox"/> Arthritis or rheumatism <input type="checkbox"/> Chronic nosebleeds <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Headaches	<input type="checkbox"/> Dislocated shoulder <input type="checkbox"/> Hernia <input type="checkbox"/> Swollen, hyper-mobile or painful joints <input type="checkbox"/> Knee disorder
<input type="checkbox"/> Asthma, allergies - If you check this box, please answer the following question. Does your son or daughter require an epi-pen? Circle: Yes or No		

Parent E-mail: _____

Provide pertinent details of any conditions above: _____

What medication(s) should the participant have on hand during the sport activity? _____

Does your son/daughter wear a medic alert bracelet _____, neck chain, _____, or carry a medic alert card? If yes, please specify what is written on it: _____

Does your son/daughter wear eyeglasses or contact lenses? If yes, please specify. _____

Other relevant medical condition(s) that will require modification of the program, or specific activities that your child should not participate in (please provide medical reason): _____

I acknowledge that the information I have provided is correct and give consent to the PE Instructor to use the above information for the purposes described above for Quarter _____ Year _____

Parent Signature: _____

Date: _____