

## PERMISSION SLIP FOR PARTICIPATION IN ATHLETICS

DEADLINE: \_\_\_\_\_

I hereby give permission for:

Name of Student	Gender	Grade	Date of Birth

to represent the East Hampton Public Schools in: (Please check only one activity.)

<input type="checkbox"/> Soccer	<input type="checkbox"/> Volleyball	<input type="checkbox"/> Cross Country	<input type="checkbox"/> Football	<input type="checkbox"/> Cheering
<input type="checkbox"/> Basketball	<input type="checkbox"/> Indoor Trk	<input type="checkbox"/> Baseball	<input type="checkbox"/> Softball	<input type="checkbox"/> Golf
<input type="checkbox"/> Track	<input type="checkbox"/> Tennis	<input type="checkbox"/> Other: _____		

Specify

realizing that such activity involves the potential for injury which is inherent in all sports. I acknowledge that even with the best coaching, use of the most advanced protective equipment, and strict observance of rules, injuries are still a possibility. On rare occasions these injuries can be so severe as to result in total disability, paralysis, or even death.

**Participation requirements:**

I understand that my son/daughter must have a physical examination:

1.  My child has had a physical within one year of the ending date of this activity.  
Date of last physical: \_\_\_\_\_  
Month Day Year
- a.  I will phone the school nurse to confirm that the school has this information.
- b.  I will ask the doctor to forward the physical results to the school.
  
2.  A physical examination will be conducted by a physician who will complete the required form. Please return completed form to the school prior to try-outs scheduled on: \_\_\_\_\_  
Date
  
3.  I understand that I must return a completed Emergency Treatment Card in order to practice and/or participate in the sport.

If you are not covered by a family health insurance policy, the Board of Education carries insurance for interscholastic sports participants. No student is obligated to purchase the student insurance package.

A plan of insurance covering interscholastic sports has been purchased by the Board of Education and represents no cost to you, the parents, or to your child. The form of coverage for athletes provides that valid claims for injuries received as a result of participating in interscholastic athletics will be paid on an excess basis. This means that the town-provided insurance will pay any amount of a valid claim in excess of that portion already satisfied by all other coverage; for example, your own family medical coverage. This plan does not cover physical education classes.

**By signing this form, the parent/guardian acknowledges that they have read and understand the information contained on this form.**

Prospective Player's Signature	Parent/Guardian
Date	Telephone Number

East Hampton Public Schools  
**EMERGENCY TREATMENT CARD**

This information will be released to the coach and emergency treatment personnel.

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sport: \_\_\_\_\_

Home Address: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Alternate Contact: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Preferred Hospital: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Medications Taken (home/school): \_\_\_\_\_ Known Allergies: \_\_\_\_\_

Known Physical/Medical Problems: \_\_\_\_\_

Check here and use other side for any additional information.

I give permission to appropriate school staff or their designees to render emergency treatment associated with an injury and I agree to hold the East Hampton Board of Education, its employees and its agents harmless in the administration of such emergency medical assistance. In cases of acute emergencies, where neither parent/guardian nor the alternate emergency individual identified above may be reached, permission is granted for my son/daughter to be transported and treated at a local emergency medical center. If any of the above information changes, I will contact the school nurse immediately.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

East Hampton High School 365-4030

East Hampton Middle School 365-4060