

PARENT'S PERMISSION FORM

****Please use blue or black ink to complete****

Grade: _____

Athlete's Name _____ Male _____ Female _____
(Last Name) (First Name)

Equipment will not be issued until this completed form is on file in the athletic office. Your signatures indicate you are giving permission for your child to practice and compete in the interscholastic program and that your child has been examined by a physician within the last calendar year.

INSURANCE INFORMATION

Board of Education Policy 730.02 of Community Unit School District #205 requires that students who participate in interscholastic sports have adequate medical/health insurance protection. The regular school day insurance provided for the current school year covers all school sponsored athletics, EXCEPT GRADES 9-12 FOOTBALL.

Please check one of the following:

We are adequately and currently covered by insurance. We agree to notify GHS Athletic Office of ANY insurance change. I understand school insurance is only supplemental and I do not wish to purchase additional coverage.

Medical Insurance Co. _____ Policy No. _____

I do not have adequate insurance and I agree to purchase the accident policy made available through the school. Parental contact must be made to the GHS Athletic Office to purchase insurance.

We realize the potential for injury that is inherent in all sports. We acknowledge that even with the best coaching, use of advanced protective equipment, and strict observances of rules, injuries are still a possibility. We hereby assume all the risks associated with participation and agree to hold Community Unit School District 205, its employees, agents, coaches, and volunteers harmless from any and all liability, actions, cause of actions, claims, debts or demands of any kind and nature whatsoever which may arise by or in connection with participation in any activities related to Community Unit School District 205 athletics.

Parent's/Guardian's Signature _____ Date _____

IHSA STEROID TESTING POLICY –CONSENT TO RANDOM TESTING

By signing below, we consent to random testing in accordance with the IHSA's Steroid testing policy. We understand that, if the student or the student's team participates in state series competitions, the student may be subject to testing for banned substances.

Athlete Signature _____ Date _____

Parent's/Guardian's Signature _____ Date _____

ATHLETIC CODE APPROVAL

We have read the rules and regulations of the Illinois High School Association and the Athletic Code as printed in the Secondary Code of Student Conduct or in the athletic handbook. The requirements set forth in the Athletic Code are minimum requirements and that each coach of any particular sport may impose other rules as they see fit. The administration is available for clarification or understanding of this code.

As an athlete representing Galesburg High School, I agree to conduct myself year round in accordance with the provisions set forth therein, and realize that participation in interscholastic athletics is a privilege, not a right. I understand that if I violate any part of the Code, I will forfeit my privilege to take part in any extra-curricular activities in accordance with the penalties.

As a parent of a Galesburg High School athlete, I will help teach my child to respect these standards year round and agree to endorse my child's adherence to the Code.

Athlete Signature _____ Date _____

Parent's/Guardian's Signature _____ Date _____

MEDICAL TREATMENT FORM

****Please use blue or black ink to complete****

Grade: _____

Athlete's Name _____ Male _____ Female _____

Parent/Guardian's Name _____

Address _____ Date of Birth _____

Home Phone _____

Cell Phone (Dad) _____ Cell Phone (Mom) _____

Work Phone (Dad) _____ Work Phone (Mom) _____

Additional emergency number other than listed above, if parent cannot be reached:

Name _____ Relation _____ Phone _____

Family Doctor _____ Phone _____

Family Dentist _____ Phone _____

Hospital Preference _____

HEALTH HISTORY

Are there any significant findings (previous and/or current) the school medical/coaching staff should be aware of:

_____ Head/neck/spine injuries	_____ Loss of paired organs (i.e. kidneys)
_____ Bone/joint/muscle injuries	_____ Medications (List names/doses below)
_____ Heart condition	_____ Allergic to medicines, insect bites, other
_____ Asthma	_____ Diabetes
_____ Seizure disorder	_____ Wears contacts
_____ Other medical conditions (describe) _____	

Please explain any of the above, especially medications and allergies: _____

In the event of an illness/injury requiring medical attention (first-aid, and/or emergency care), I hereby give my permission to the attending sports medicine personnel (i.e. certified athletic trainer, physician) and/or hospital personnel designated by the Community Unit School District No. 205 Coaching Staff to attend to my son or daughter. I also give my consent to the attending sports medicine personnel to discuss my child's medical condition with his/her coach and district certified athletic trainer. I expect every effort will be made to contact me in order to receive my specific authorization before any further treatment or hospitalization is undertaken.

Parent's/Guardian's Signature _____ Date _____

****Students will not be allowed to participate if this form is not completed or signed in full.****

Revised
June 2, 2009