

OFFICE USE ONLY
ASB _____ Ath Code _____ Clearance Date _____

Castle Rock School District Athletic Card

This Section to be Completed by Student/Parent/Guardian

Confidential

Circle School Attending in 2006-07: C.R. Middle School C.R. High School Student ID No. _____

Instructions: **Please Print** all information except signatures.

Name _____ Parent/Guardian Name _____

Address _____ City _____

Phone _____ Bus. Phone: Father _____ Mother _____

Grade in 2006-07 _____ Birthdate _____ Sex: Male _____ Female _____

Two persons we may call in the event your parents cannot be reached:

_____ Phone _____

_____ Phone _____

This application to compete in interscholastic athletics for the above school is entirely voluntary on my part and is made with the understanding that I have not violated any of the eligibility rules or regulations of the school or state association.

Sports in which I plan to participate: 1 _____ 2 _____ 3 _____ 4 _____

Student Signature _____ Date _____

WARNING

Participation in any athletic activity will likely involve injury of some type to either yourself or a fellow student athlete. Such injury can include direct physical and possibly crippling injury to one's body and the possibility of emotional injury experienced as a result of witnessing or actually inflicting injury to another. The severity of such injury can range from minor cuts, scrapes, or muscle strains to catastrophic injury, such as complete paralysis, or even death. Such injury can impair one's general physical and mental health and hinder one's future ability to earn a living, to engage in other business, social, and recreational activities, and generally to enjoy life.

ATHLETIC INSURANCE INFORMATION

This Section to be completed by Parent/Guardian

All school athletes must be covered by medical insurance provided by parent/guardian for the duration of the athletic activity(ies) in which they participate. *Inform the school immediately should there be a change in insurance coverage.*

Parent/guardian, please initial at least one of the following to indicate current coverage.

_____ 1. Complete personal coverage with _____
(Name of Insurance Company)

_____ 2. Student insurance plan (to be purchased by parent/guardian *prior to participating in activity*).

Name of Family Physician Address Phone

PARENT'S OR GUARDIAN'S PERMISSION

This Section to be Completed by Parent/Guardian

Do you give permission for this student to take a physical examination from a school selected physician? Yes _____ No _____

Do you give permission for a physician to administer treatment to your child and to inform school officials of the nature of the Injury? Yes _____ No _____

It is the parent's/guardian's responsibility to notify the school any time a medical problem occurs that would affect the health of the student as he/she participates in athletics.

I have read and completed all of the sections of this card and all statements are true to the best of my knowledge. I hereby give my consent for the above student to engage in school and state association approved athletic activities as a representative of his/her school. I also give my consent for this student to accompany the team when it travels to other schools.

Parent/Guardian Signature _____ Date _____

