(This form gets returned to the Coach)

LAKOTA SCHOOL DISTRICT
ATHLETIC DEPARTMENT

STUDENT INFORMATION FORM - SCHOOL YEAR '09-'10

NAME ______________________________ *SPORT* ______________________
(Last) *(First)*

ADDRESS ______________________________ *PHONE* ________________

______________________________ *ZIP* ____________

AGE ________ *PRESENT GRADE* __________ *BIRTH DATE* ____________________
(Month/Day/Year)

FATHER'S/GUARDIAN'S NAME ______________________ *WORK PHONE* ____________

MOTHER'S/GUARDIAN'S NAME ______________________ *WORK PHONE* ____________

O.H.S.A.A. ELIGIBILITY INFORMATION

Question	*Please Circle*		
1. Did you attend a Lakota school last year?	1.	YES	**NO***
2. Are you a foreign exchange student?	2.	**YES***	NO
3. Are you currently enrolled in a Lakota school?	3.	YES	**NO***
4. Are you currently enrolled in at least five solid subjects?	4.	YES	**NO***
5. Are you currently living with your parent(s)/legal guardian(s) at the above listed address?	5.	YES	**NO***
6. Is Lakota High School the only high school you have ever attended?	6.	YES	**NO***
7. Have you ever withdrawn from high school?	7.	**YES***	NO
8. Is this coming semester your ninth semester or more of high school? (high school is grades 9 through 12)	8.	**YES ***	NO
9. Will you be 19 years old before August 1st in grades 10, 11 or 12?	9.	**YES***	NO

IF ANY CHANGES TO THE ABOVE INFORMATION SHOULD OCCUR DURING THIS SPORTS SEASON, PLEASE NOTIFY YOUR HEAD COACH AND THE DISTRICT ATHLETIC DIRECTOR IMMEDIATELY. FAILURE TO DO SO COULD AFFECT YOUR ELIGIBILITY TO PARTICIPATE IN THIS SPORT AND POSSIBLY CAUSE FORFEITURE OF CONTESTS.

Please read all the training rules and eligibility requirements contained in your athletic handbook before signing this form. Your signature indicates that you have read and you are aware of your responsibilities as a Lakota athlete. Likewise, the parent(s) and/or guardian(s) signature indicates an acknowledgement of the responsibilities of a Lakota athlete.*

Student Signature ______________________________ *Date* ____________________

Parent/Guardian Signature ______________________ *Date* ____________________

(6/09)

(This form gets returned to the Coach)

STUDENT TRAINING PLEDGE

As a participant in the Lakota athletic program, I agree to abide by all training rules, especially those regarding the use, sale and/or possession of alcohol/drugs/tobacco. Chemical dependency is a progressive but treatable disease characterized by repeated alcohol and/or drug use in spite of recurring problems. Therefore, I accept and pledge to abide by the training rules listed in the Student Athletic Handbook, the Student Code of Conduct as established by the Lakota Board of Education, and all other rules established by the coach of my sport.

To demonstrate my support, I pledge to:

1. **Support my fellow students by setting an example and abstaining from the use/possession of drugs/tobacco/alcohol.**

2. **Not to enable my fellow students, who use drugs/alcohol/tobacco, I will not cover for them or lie for them if any rules are broken. I will hold my teammates accountable for their actions.**

3. **Seek information and assistance in dealing with my own or teammates' problems.**

4. **Be honest with my parents about feelings, needs, and problems.**

5. **Be honest with my coach or other school personnel when the best interests of my fellow students are jeopardized.**

STUDENT SIGNATURE ____

DATE ____

(6/15/06)

(This form gets returned to the Coach)

LAKOTA DISTRICT ATHLETIC DEPARTMENT

RELEASE

We, the undersigned, student and parent(s)/guardian(s) of ______________________*(student name)* do hereby release, waive, discharge and covenant not to sue the Lakota School District Board of Education, its individual members, Superintendent, principals, administrators, employees, agents or anyone acting on its behalf, from any and all liability, claim, demand, action or cause of actions, of whatever kind or nature, either in law or equity, arising from or by reason of any bodily injury, personal injury or mental injury, known or unknown, including death, resulting from or to result from __________________'s *(student name)*participation in sports and/or any other extracurricular activity on behalf of or in the name of the Lakota School District Board of Education.

We hereby assume full responsibility for the risk of bodily injury, personal injury or mental injury or death due to _________________'s *(student name)* participation in sports and/or other extracurricular activities on behalf of or in the name of the Lakota School District Board of Education.

We expressly agree that his/her release is intended to be as broad and inclusive as permitted by the laws of the State of Ohio or any other state in which said student may be injured and that if any portion of this release is held invalid, it is agreed that the balance shall, nevertheless, continue in full force and effect.

We further state that I/we have carefully read the above release and know the contents of same and sign this release of our own free act.

Dated: ______________________ ______________________________

(Parent/Guardian)

Dated: ______________________ ______________________________

(Parent/Guardian)

Dated: ______________________ ______________________________

(Student)

(6/09)

(Both the Coach and Trainer need copies of this form)

LAKOTA SCHOOL DISTRICT EMERGENCY MEDICAL AUTHORIZATION

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parent or guardians cannot be reached.

Please use Blue or Black ink.

Student Address________________________________ **Student Name**________________________________ Sex M / F
________________________________Zip ________ School ________________________________

Home Phone # ________________________ Grade ________ Date of Birth __________Home Room # _____

Father's Name ________________________________ Work Phone ________________
Address (if different than student)________________________ Home Phone ________________
E-mail address ________________________________ Cell/Pgr ________________
Step Mothers Name ________________________________ Work Number ________________

Mother's Name ________________________________ Work Phone ________________
Address (if different than student)________________________ Home Phone ________________
E-mail address ________________________________ Cell / Pgr ________________
Step Father's Name ________________________________ Work Number ________________

Guardian's Name________________________________ Work Phone ________________
(if other than parents)
E-mail address________________________________Cell/Pgr ________________

Person(s) who may be notified and to whom your child may be released if school cannot reach you.
1. ________________________Relationship____________________Phone____________________
2. ________________________Relationship____________________Phone____________________
3. ________________________Relationship____________________Phone____________________

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted: ____
____
____

The School Nurse may share health information with appropriate school personnel to aid in present and future educational decisions.

Doctor to be called________________________________ Phone________________________
Dentist to be called________________________________ Phone________________________
Preferred local hospital____

PART 1-TO GRANT CONSENT

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above named doctor or in the event the designated preferred practitioner is not available by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentists concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

Date______________ **Signature of Parent / Guardian**____

PART 2- TO REFUSE CONSENT

I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take NO action or to: ____
____

Date ______________**Signature of Parent / Guardian**____

(6/15/06)

(This form gets returned to the Trainer)

Lakota School District

ATHLETIC TRAINING

Please read, sign, and return to us the following consent form.
If you are under 18 years of age, your parents must also sign.

If you should choose to refuse to sign this consent form, please write "refused to sign", the date, and your signature on the signature line.

INFORMED AND MEDICAL CONSENT

I, ______________________________ *(print name)*, am aware that trying out, practicing, or playing in any sport can be a dangerous activity involving many risks or injury. I understand that the dangers and risks include, but are not limited to, death, serious head, neck, and spinal injuries, paralysis, injuries or impairment to the musculoskeletal system, or other aspects of the body, general health, and well-being.

Because of the dangers of participating in sports, I recognize the importance of following the instructions of the athletic department personnel regarding playing techniques, training, rules of the team/sport, equipment, and to obey such rules. I also acknowledge that some sports are classified as violent sports involving even a greater risk of injury than other sports. I further realize that I am expected to report all injuries/illnesses I may have sustained during periods of official, organized athletic participation (including all regularly scheduled practices and contests) and throughout the calendar year (regardless of how they occurred) to a coach, an athletic trainer, or to a team physician.

I hereby grant permission to the Lakota School District team physicians and/or their consulting physicians to render to myself (son/daughter) any treatment, medical or emergency surgical care that they deem reasonably necessary to the health and well-being of the student-athlete.

I also hereby authorize the Lakota School District athletic trainers and their staff who are under the direction and guidance of the Lakota School District team physicians to render to myself (son/daughter) any preventive measures for injuries, first aid, treatment, rehabilitation, or emergency treatment that they deem reasonable and necessary to the health and well-being of the student-athlete. This includes all practices, games, and travel.

Also, when necessary for executing such care, I grant permission for hospitalization at an accredited hospital.

DATE ______________________________

____
Signature

(Signature may be that of the student-athlete over 18 years of age; if under 18, this form must also be signed by a parent or guardian.)

____
Social Security # (OPTIONAL)

____
Parent/Guardian Signature

(6/15/06)

LAKOTA LOCAL SCHOOL DISTRICT
AUTHORIZATION TO PUBLISH STUDENT NAME WITH PICTURE ON LAKOTA WEBSITES

HIGH SCHOOL STUDENTS

Photographs or video identifying high school students by name may be published on the district's website and athletic websites unless the student's parent/guardian (or student over the age of 18) has denied authorization. Failure to return this form denying permission could result in your high school student's photograph being identified on a Lakota District website. I understand that the student's photograph could be published as an individual photograph or as a group picture without identifying the student unless denied under FERPA.

______**I deny authorization** to publish student's name with their photograph on a district website.

Name of student (print): ______________________________ School ______________________

____ Date______________________________
Parent/Guardian Signature (if under 18)

____ Date ______________________________
Student Signature (if over 18)

Address ____________________________________ Phone: ____________________________

ELEMENTARY STUDENTS

Early elementary, elementary or junior high school students will not be identified in a photograph or video on Lakota district websites unless permission is granted by the student's parent/guardian.

______**I authorize** the Lakota Local School District to publish student's name with their photograph on a district website.

______**I deny authorization** to publish student's name with their photograph on a district website.

Name of student (print): ____________________________ School ________________________

____ Date______________________________
Parent/Guardian Signature

Address ____ Phone: __________________

Lakota Local School District Form 6301D
Cross-Reference: Board Policy 6301

Revised 12/4/08

Ohio High School Athletic Association
Preparticipation Physical Evaluation

DATE OF EXAM:______________________

Name ______________________ Sex ________ Age ______ Date of Birth ____________

Grade______ School ______________ Sport(s) ______________________

Address ______________________________ Phone ______________

Personal Physician______________________________

In case of emergency, contact: *Name* ______________ *Relationship* ____________

Phone (H) ____________ *(W)* ____________ *(Cell)* ____________ *(Cell)* ____________

History

This section is to be carefully completed by the student and his/her parent(s) or legal guardian(s) before participation in interscholastic athletics in order to help detect possible risks.

Explain "YES" answers in the space provided. Circle questions you don't know the answer to.

	Yes	No
1. Has a doctor ever denied or restricted you participation in sports for any reason?	☐	☐
2. Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	☐
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5. Do you think you are in good health?	☐	☐
6. Have you ever passed out or nearly passed out DURING exercise?	☐	☐
7. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
8. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
9. Does your heart race or skip beats during exercise?	☐	☐
10. Has a doctor ever told you that you have (check all that apply): ☐ High Blood Pressure ☐ A heart murmur ☐ High Cholesterol ☐ A heart infection		
11. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)	☐	☐
12. Has anyone in your family died for no apparent reason?	☐	☐
13. Does anyone in your family have a heart problem?	☐	☐
14. Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
15. Does anyone in your family have Marfan syndrome?	☐	☐
16. Have you ever spent the night in a hospital?	☐	☐
17. Have you ever had surgery?	☐	☐
18. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below:	☐	☐
19. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	☐	☐
20. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	☐	☐

Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand / Fingers	Chest
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot / Toes

	Yes	No
21. Have you ever had a stress fracture?	☐	☐
22. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
23. Do you regularly use a brace or assistive device?	☐	☐
24. Has a doctor ever told you that you have asthma or allergies?	☐	☐
25. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
26. Is there anyone in your family who has asthma?	☐	☐
27. Have you ever used an inhaler or taken asthma medicine?	☐	☐
28. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
29. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
30. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
31. Have you had a herpes skin infection?	☐	☐
32. Have you ever had a head injury or concussion?	☐	☐
33. Have you been hit in the head and been confused or lost your memory?	☐	☐
34. Have you ever had a seizure?	☐	☐
35. Do you have headaches with exercise?	☐	☐
36. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
37. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
38. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
39. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
40. Have you had any problems with your eyes or vision?	☐	☐
41. Do you wear glasses or contact lenses?	☐	☐
42. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
43. Are you happy with your weight?	☐	☐
44. Are you trying to gain or lose weight?	☐	☐
45. Has anyone recommended you change your weight or eating habits?	☐	☐
46. Do you limit or carefully control what you eat?	☐	☐
47. Do you have any concerns that you would like to discuss with a doctor?	☐	☐

FEMALES ONLY

	Yes	No
48. Have you ever had a menstrual period?	☐	☐
49. How old were you when you had your first menstrual period?	____	
50. How many periods have you had in the last 12 months?	____	

Explain "Yes" Answers Here: (Attach additional sheets as needed)

____

____

____

____

____

I (we) hereby state, to the best of my (our) knowledge, my (our) answers to the above questions are complete and correct.

Signature: ______________________ Signature: ______________________ Date: __________

Athlete — Parent or Guardian (If athlete is under 18)

The student has family insurance ☐ Yes ☐ No; If yes, family insurance company name and policy number: ______________

NOTE: CONSENT AND HIPAA RELEASE FORMS THAT MUST BE SIGNED BY BOTH THE PARENT AND THE STUDENT ARE ON A SEPARATE SHEET.
NOTE: HISTORY AND ALL CONSENT FORMS MUST BE COMPLETED PRIOR TO PHYSICAL EXAMINATION

Modified from American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine, 2004. Rev. 03/06

Physical Examination Form

The section below is to be completed by physician or staff after history and consent forms are completed.

Students Name________________ **Birth Date**________________

Height______ **Weight**________ **% Body Fat** (optional)________ **Pulse**______ **BP**_____/_____, _____/_____, _____/_____

Vision R 20/ ________ **L 20/** ________ **Corrected:** Y N **Pupils:** **Equal** ______ **Unequal** ______

Follow-Up Questions on More Sensitive Issues (Optional)

1. Do you feel stressed out or under a lot of pressure?
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?
3. Do you feel safe?
4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke?
5. During the past 30 days, did you use chewing tobacco, snuff, or dip?
6. During the past 30 days, have you had at least 1 drink of alcohol?
7. Have you ever taken steroid pills or shots without a doctor's prescription?
8. Have you ever taken any supplements to help you gain or lose weight or improve your performance?
9. Questions from the Youth Risk Behavior Survey (http://www.cdc.gov/HealthyYouth/yrbs/index.htm) on guns, seatbelts, unprotected sex, domestic violence, drugs, etc.

Notes: ________________

MEDICAL	Normal	Abnormal findings	Initials*
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

*Multiple-examiner set-up only.

Notes: ________________

Clearance

- ☐ Cleared without restriction
- ☐ Cleared, with recommendations for further evaluation or treatment for: ________________

☐ Not cleared for: ☐ All Sports ☐ Certain sports: ________________ Reason: ________________

Recommendations: ________________

Emergency Information:

Allergies: ________________

Other Information: ________________

Name of Physician: (print/type/stamp) ________________ (M.D., D.O., D.C.) Date: ________________

If the Physician's Assistant (P.A.) or Advanced Nurse Practitioner (A.N.P.) performed the exam, name and address of collaborating physician or physician group:

Address: ________________ Phone: ________________

Signature of Physician: ________________

OHSAA AUTHORIZATION FORM

I hereby authorize the release and disclosure of the personal health information of ________________________________ ("Student"), as described below, to ________________________________ ("School").

The information described below may be released to the School principal or assistant principal, athletic director, coach, athletic trainer, physical education teacher, school nurse or other member of the School's administrative staff as necessary to evaluate the Student's eligibility to participate in school sponsored activities, including but not limited to interscholastic sports programs, physical education classes or other classroom activities.

Personal health information of the Student which may be released and disclosed includes records of physical examinations performed to determine the Student's eligibility to participate in school sponsored activities, including but not limited to the Pre-participation Evaluation form or other similar document required by the School prior to determining eligibility of the Student to participate in classroom or other School sponsored activities; records of the evaluation, diagnosis and treatment of injuries which the Student incurred while engaging in school sponsored activities, including but not limited to practice sessions, training and competition; and other records as necessary to determine the Student's physical fitness to participate in school sponsored activities.

The personal health information described above may be released or disclosed to the School by the Student's personal physician or physicians; a physician or other health care professional retained by the School to perform physical examinations to determine the Student's eligibility to participate in certain school sponsored activities or to provide treatment to students injured while participating in such activities, whether or not such physicians or other health care professionals are paid for their services or volunteer their time to the School; or any other EMT, hospital, physician or other health care professional who evaluates, diagnoses or treats an injury or other condition incurred by the student while participating in school sponsored activities.

I understand that the School has requested this authorization to release or disclose the personal health information described above to make certain decisions about the Student's health and ability to participate in certain school sponsored and classroom activities, and that the School is a not a health care provider or health plan covered by federal HIPAA privacy regulations, and the information described below may be redisclosed and may not continue to be protected by the federal HIPAA privacy regulations. I also understand that the School is covered under the federal regulations that govern the privacy of educational records, and that the personal health information disclosed under this authorization may be protected by those regulations.

I also understand that health care providers and health plans may not condition the provision of treatment or payment on the signing of this authorization; however, the Student's participation in certain school sponsored activities may be conditioned on the signing of this authorization.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by a health care provider in reliance on this authorization, by sending a written revocation to the school principal (or designee) whose name and address appears below.

Name of Principal: ________________________________

School Address: ________________________________

This authorization will expire when the student is no longer enrolled as a student at the school.

NOTE: IF THE STUDENT IS UNDER 18 YEARS OF AGE, THIS AUTHORIZATION MUST BE SIGNED BY A PARENT OR LEGAL GUARDIAN TO BE VALID. IF THE STUDENT IS 18 YEARS OF AGE OR OVER, THE STUDENT MUST SIGN THIS AUTHORIZATION PERSONALLY.

____

Student's Signature Birth date of Student, including year

____

Name of Student's personal representative, if applicable

I am the Student's (check one): _______ Parent _______ Legal Guardian (documentation must be provided)

____

Signature of Student's personal representative, if applicable Date

A copy of this signed form has been provided to the student or his/her personal representative

THE STUDENT SHALL NOT BE CLEARED TO PARTICIPATE IN INTERSCHOLASTIC ATHLETICS UNTIL THIS FORM HAS BEEN SIGNED AND RETURNED TO THE SCHOOL

2009-2010 Ohio High School Athletic Association Eligibility and Authorization Statement

This document is to be signed by the participant from an OHSAA member school and by the participant's parent.

- I have read, understand and acknowledge receipt of the OHSAA brochure entitled "Your Athletic Eligibility," which contains a summary of the eligibility rules of the Ohio High School Athletic Association. I understand that a copy of the *OHSAA Handbook* is on file with the principal and athletic administrator and that I may review it, in its entirety, if I so choose. All OHSAA bylaws and regulations from the *Handbook* are also posted on the OHSAA web site at www.ohsaa.org.
- I understand that an OHSAA member school must adhere to all rules and regulations that pertain to the interscholastic athletics programs that the school sponsors, but that local rules may be more stringent than OHSAA rules.
- I understand that participation in interscholastic athletics is a privilege not a right.

Student Code of Responsibility

- As a student athlete, I understand and accept the following responsibilities:
  - I will respect the rights and beliefs of others and will treat others with courtesy and consideration
  - I will be fully responsible for my own actions and the consequences of my actions
  - I will respect the property of others
  - I will respect and obey the rules of my school and laws of my community, state and country
  - I will show respect to those who are responsible for enforcing the rules of my school and the laws of my community, state and country
  - I understand that a student whose character or conduct violates the school's Athletic Code or School Code of Responsibility is not in good standing and is ineligible for a period of time as determined by the principal
- **Informed Consent** – By its nature, participation in interscholastic athletics includes risk of injury and transmission of infectious disease such as HIV and Hepatitis B. Although serious injuries are not common and the risk of HIV transmission is almost nonexistent in supervised school athletic programs, it is impossible to eliminate all risk. Participants have a responsibility to help reduce that risk. Participants must obey all safety rules, report all physical and hygiene problems to their coaches, follow a proper conditioning program, and inspect their own equipment daily. **PARENTS, GUARDIANS OR STUDENTS WHO MAY NOT WISH TO ACCEPT RISK DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS FORM. STUDENTS MAY NOT PARTICIPATE IN AN OHSAA-SPONSORED SPORT WITHOUT THE STUDENT'S AND PARENT'S/GUARDIAN'S SIGNATURE.**
- I understand that in the case of injury or illness requiring transportation to a health care facility, that a reasonable attempt will be made to contact the parent or guardian in the case of the student-athlete being a minor, but that, if necessary, the student-athlete will be transported via ambulance to the nearest hospital.
- To enable the OHSAA to determine whether the herein named student is eligible to participate in interscholastic athletics in an OHSAA member school I consent to the release to the OHSAA any and all portions of school record files, beginning with seventh grade, of the herein named student, specifically including, without limiting the generality of the foregoing, birth and age records, name and residence address of parent(s)or guardian(s), residence address of the student, academic work completed, grades received and attendance data.
- I consent to the OHSAA's use of the herein named student's name, likeness, and athletic-related information in reports of contests, promotional literature of the Association and other materials and releases related to interscholastic athletics.
- By signing this we acknowledge that we have read the above information and that we consent to the herein named student's participation.

***Must Be Signed Before Physical Examination**

Student's Signature ______ Birth date ______ Grade in School ______ Date ______

Parent's or Guardian's Signature ______ Date ______