

10/1/2008

**BENZIE CENTRAL ATHLETIC DEPARTMENT**

Parents and/or Guardians:

The following is a permission form that must be completed and signed by you and your student athlete before they may participate in an interscholastic athletic event for Benzie Central Schools. In signing this letter you should be aware of the following important points:

1. Benzie Central Schools **DOES NOT** provide an insurance program covering health or injury problems resulting from athletics. It is the responsibility of the athlete and their family to provide such insurance and to take care of any medical expenses.
2. In signing this form you are giving your student athlete permission to travel under the coach's direction and authority to and from athletic events.
3. The coaches shall have the authority to seek medical attention in case of injury in any athletic gathering (practice, contests or authorized team activity).
- 4.

**STUDENT ATHLETE EMERGENCY INFORMATION FORM**

Athlete Name: \_\_\_\_\_

Birth date: \_\_\_\_\_ Grade: \_\_\_\_\_ Gender: Male Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Phone (home/cell): \_\_\_\_\_ Work (mom/dad): \_\_\_\_\_

**IF AN EMERGENCY SHOULD OCCUR AND PARENTS CANNOT BE REACHED THE FOLLOWING INDIVIDUALS WILL BE CALLED.**

Emergency #1 \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency #2 \_\_\_\_\_ Phone: \_\_\_\_\_

Physician \_\_\_\_\_ Phone: \_\_\_\_\_

Hospital Choice \_\_\_\_\_

In case of accident or serious illness, I request the school contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated and to follow their instructions. If the physician cannot be reached the school may make whatever arrangements deemed necessary for the well being of the child. I understand medical information may be provided to the Athletic Department for my child to participate in interscholastic athletics. This information will be treated with full confidentiality by this department.

Athlete Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

**MEDICAL HISTORY**

Indicate any issues we need to be aware of for the health and well being of your student -

ALLERGIES \_\_\_\_\_ ASTHMA \_\_\_\_\_

SEIZURES \_\_\_\_\_ DIABETIES \_\_\_\_\_

CARDIAC \_\_\_\_\_ SURGERIES \_\_\_\_\_

CURRENT MEDICATIONS \_\_\_\_\_