|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Emporia Greensville Recreation Association**  Athletic Participation/Parental Consent/Physical Examination Form  **New Physical Examination is required each year.**  **Part 1 – Athletic Participation**  **(To be filled in and signed by the student)**  **PARTICIPANT'S GRADE \_\_\_\_\_\_\_\_\_ AGE \_\_\_\_\_\_\_\_ SCHOOL NAME**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Year:** \_\_\_\_\_\_\_\_ **Male:** \_\_\_\_\_\_\_\_ **Female:**\_\_\_\_\_\_\_\_  **Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (**Print Please** - *First, MI, Last*)  **Home Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **City/Zip Code:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Home Address of Parents/Guardian:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **City/Zip Code:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Place of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cellular Number:** \_\_\_\_\_\_\_\_\_\_  **Individual Eligibility Rules**  **An Athletic Participation/Parental Consent/Physical Examination Form must be completely filled in and properly signed attesting that you have been examined during this year and found to be physically fit for athletic competition and that your parents consent to your participation.**  **Participants Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_  **Parent/Guardian Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_  **PART II - - MEDICAL HISTORY** | | | | | |
| This form **MUST** be completed by parent or guardian **PRIOR** to the physical examination and should be taken with the physical examination form for review by the physician during the examination. | | | | | |
| *Explain “Yes” answers on separate sheet of paper with number of the question. Circle questions you don’t know the answers to.* | | | | | |
| **YES NO** | | **MEDICAL HISTORY OF STUDENT & FAMILY Yes No** | **YES** | **NO** | **MEDICAL HISTORY OF STUDENT & FAMILY Yes No** |
|  |  | 1. Has a doctor ever denied or restricted your participation in sports for any reason? |  |  | 34. Have you ever had a head injury or concussion? |
|  |  | 2. Do you have an ongoing medical condition (like diabetes or asthma? |  |  | 35. Date of last head injury or concussion:  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  | 3. Are you currently taking any prescription or non prescription (over the counter) medicines or pills? |  |  | 36. Have you ever been hit in the head and been confused or lost your memory? |
|  |  | 4. Do you have allergies to medicines, pollens, foods or stinging insects? |  |  | 37. Have you ever been knocked unconscious? |
|  |  | 5. Do you have prescriptions for use of epinephrine, adrenalin, inhaler, or other allergy medications? |  |  | 38. Have you ever had a seizure? |
|  |  | 6. Have you ever passed out or nearly passed out during or after exercise? |  |  | 39. Do you have headaches with exercise? |
|  |  | 7. Have you ever passed out or nearly passed out at any other time? |  |  | 40. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? |
|  |  | 8. Have you ever had discomfort, pain, or pressure in your chest during exercise? |  |  | 41. Have you ever been unable to move your arms or legs after being hit or falling? |
|  |  | 9. Have you ever had to stop running after ¼ to ½ mile for chest pain or shortness of breath? |  |  | 42. When exercising in heat, do you have severe muscle cramps or become ill? |
|  |  | 10. Does your heart race or skip beats during exercise? |  |  | 43. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? |
|  |  | 11. Has a doctor ever told you that you have (check all that apply): |  |  | 44. Have you had any other blood disorders or anemia? |
|  |  | High Blood Pressure A heart murmur |  |  | 45. Have you had any problems with your eyes or vision? |
|  |  | High cholesterol A heart infection |  |  | 46. Do you wear glasses or contact lenses? |
|  |  | 12. Has a doctor ever ordered a test for your heart? |  |  | 47. Do you wear protective eyewear, such as goggles or a face shield? |
|  |  | 13. Has anyone in your family died suddenly for no apparent reason? |  |  | 48. Are you happy with your weight? |
|  |  | 14. Does anyone in your family have a heart problem? |  |  | 49. Are you trying to gain or lose weight? |
|  |  | 15. Has any family member or relative died of heart problems or sudden death before age 50? (This does not include accidental death) |  |  | 50. Do you limit or carefully control what you eat? |
|  |  | 16. Does anyone in your family have Marfan syndrome? |  |  | 51. Has anyone recommended you change your weight or eating habits? |
|  |  | 17. Have you ever spent the night in a hospital? |  |  | 52. Do you have any concerns that you would like to discuss with a doctor? |
|  |  | 18. Have you ever had surgery? |  |  | 53. What is the date of your last Tetanus immunization?  Date: \_\_\_\_\_\_\_ |
|  |  | 19. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or game? |  |  | 54. Do you have any other significant health problems? |
|  |  | 20. Have you had any broken or fractured bones or dislocated joints? |  |  | **FEMALES ONLY** |
|  |  | 21. 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? |  |  | 54. Have you ever had a menstrual period? |
|  |  | 22. Have you ever had a stress fracture? |  |  | 55. Age when you had your first menstrual period? \_\_\_\_ |
|  |  | 23. Have you ever had an x-ray of your neck for atlanto-axial instability? OR Have you ever been told that you have that disorder or any neck/spine problem? |  |  | 56. How many periods have you had in the last 12 months? \_\_\_\_\_\_\_ |
|  |  | 24. Do you regularly use a brace or assistive device? |  |  | 57. Do you take a calcium supplement? |
|  |  | 25. Have you ever been diagnosed with asthma or other allergic disorders? Explain “Yes” answers here: |  |  | **Explain all "YES" answers HERE!** |
|  |  | 26. Do you cough, wheeze, or have difficulty breathing during or after exercise? |  |  |
|  |  | 27. Is there anyone in your family who has asthma? |  |  |
|  |  | 28. Have you ever used an inhaler or taken asthma medicine? |  |  |
|  |  | 29. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? |  |  |
|  |  | 30. Have you had infectious mononucleosis (mono) within the last three months? |  |  |
|  |  | 31. Have you ever had mono or any illness lasting more than two weeks? |  |  |
|  |  | 32. Do you have any rashes, pressure sores, or other skin problems? |  |  |
|  |  | 33. Have you ever had herpes skin infection? |  |  |
| **Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Athlete’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | |

## **PART III – PHYSICAL EXAMINATION**

**(To be completed by examining physician)**

# **Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **School:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Height:** \_\_\_\_\_\_\_\_\_\_\_\_\_ **Weight:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Sex:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age:** \_\_\_\_\_\_\_\_\_\_\_\_ **Grade:** \_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Tanner Stage or Maturation Index:** \_\_\_\_\_\_\_\_\_\_ **BP:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Percent Body Fat** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\*Pulse(rest)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

(*Exercise*) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*Recovery*) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Vision: Corrected (L)** \_\_\_\_\_\_\_\_ **(R)** \_\_\_\_\_\_\_\_\_\_ **Both** \_\_\_\_\_\_\_\_\_\_\_

**Uncorrected**  **(L)** \_\_\_\_\_\_\_\_ **(R)** \_\_\_\_\_\_\_\_\_\_ **Both** \_\_\_\_\_\_\_\_\_\_\_

**\*Audiogram:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cervial Spine/Neck** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Back** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Shoulders** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Eyes** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Arm/Elbow/Wrist/Hand** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ears** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Knees/Hips** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nose** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Ankles/Feet** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Throat** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Teeth** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Skin** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Lymphatic** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Lungs** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Heart** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Lab:**  **Abdomen** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Urine** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Genitalia/hernia** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\*Hemoglobin or HCT** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Peripheral Pulses** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **and/or Fe Stores** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*WHEN MEDICALLY INDICATED**

(*Physician judgment based on history, exam, and knowledge of other recent physical and laboratory evaluations*)

**^WITH SPECIAL INDICATIONS**

(*These studies may be recommended to the athlete because of history or physical findings and may or may not be required before making participation decision.)*

**I have reviewed the data above, reviewed his/her medical history form and make the following recommendations for his/her participation in athletics.**

􀂉 **CLEARED WITHOUT RESTRICTIONS**

􀂉 Cleared **AFTER** further evaluation or treatment for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

􀂉 Cleared for **Limited participation** (*check and explain “reason” for all that apply*):

􀂉 Not cleared for (*specific sports*)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

􀂉 Cleared only for (*specific sports*) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason(*s*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

􀂉 **NOT CLEARED FOR PARTICIPATION**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason(*s*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

􀂉 Other Recommendations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

􀂉 Recommend close monitoring during early conditioning because of weight/fitness/other

􀂉 Recommend restrictions or monitoring of weight loss or gain

􀂉 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason(*s*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***\*Doctor of Medicine, Doctor of Osteopathy or Licensed Nurse Practitioner***

**Physician Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ + M.D. Date of Examination\*\* \_\_\_\_\_\_\_\_\_\_\_\_

(**MD, DO, LNP, PA**) **Date Signed:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Examiner’s Name and degree** (*Print*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Phone Number:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**State:** \_\_\_\_ **Zip:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### PART IV – ACKNOWLEDGEMENT OF RISK AND INSURANCE STATEMENT

(TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN)

I give permission for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (**name of child/ward**) to participate in any of the following sports that are not crossed out: baseball, basketball, cheerleading, cross country, field hockey, football, golf, gymnastics, lacrosse, soccer, softball, swimming/diving, tennis, track, volleyball, wrestling, other **(identify sports**).\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have reviewed the individual eligibility rules and I am aware that with the participation in sports comes the risk of injury to my child/ward. I understand that the degree of danger and the seriousness of the risk varies significantly from one sport to another with contact sports carrying the higher risk. I have had an opportunity to understand the risk inherent in sports through meeting, written handouts, or some other means. He/she has participant primary accident insurance available through our family policy (Yes or No)

**Name of Company:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policy Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Name of Policy Holder:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am aware that participating in sports will involve travel with the team. I acknowledge and accept the risks inherent in the sport and with the travel involved and with this knowledge in mind, grant permission for my child/ward to participate in the sport and travel with the team. I also give my consent and approval for my child to receive a physical examination, as required in **Part III, Physical Examination**, of this form, by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **M.D., D.O. or LNP.**

##### PART V – EMERGENCY PERMISSION FORM

(TO BE COMPLETED BY PARENT/GUARDIAN)

###### Participant Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Minors, Juniors or Seniors Age\_\_\_\_\_\_\_

**E.G.R.A.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Authorization:** In the event I cannot be reached in an emergency, I hereby give permission to physicians selected by the coaches and staff of E.G.R.A. to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery for the person named above.

**Daytime number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Evening Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Where to reach you in an emergency)**

**Signature of Parent/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to Participant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I certify all the above information is correct \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Parent/Guardian Signature)**

**\*Emergency Permission Form may be reproduced to travel with respective teams and is acceptable for emergency treatment if needed.**