

SPORTS PARTICIPATION PERMISSION
DEPARTMENT OF ATHLETICS - SOUTHLINGTON PUBLIC SCHOOLS

SHS Nurse FAX: 860-628-3399
DePaolo Nurse Fax: 860-628-3403
Kennedy Nurse FAX: 860-628-3404

This form is for use in the event of a medical emergency and permission to participate in sports.

Part A of this form requests information that a hospital will require prior to medical treatment.

Part B of this form is parent/guardian permission for student-athlete to participate in sports and authorizes emergency medical treatment when contacting the parent/guardian is not possible or is not practical. In that case, the parent/guardian will be contacted as soon as possible.

PART A: SPORT: _____ STUDENT ATHLETE'S NAME: _____

GRADE: _____ AGE: _____ SEX: _____ BIRTH DATE: _____

ADDRESS: _____

PARENT/GUARDIAN: _____ PHONE: _____

INSURANCE COMPANY: _____

POLICYHOLDER: _____ POLICY NUMBER: _____

EMPLOYER OF PARENT/GUARDIAN: _____

ADDRESS OF EMPLOYER: _____ PHONE: _____

OTHER CONTACT PERSON IN THE EVENT ABOVE NAMED IS UNAVAILABLE: _____

PHONE: _____ OTHER PHONE: _____

PHYSICIAN: _____ PHONE: _____

KNOWN MEDICAL PROBLEMS: Heart Condition Asthma Allergy Bleeding Disorders
 Diabetes Other: _____

STUDENT ALLERGIES TO MEDICATION, FOOD, INSECTS (EXPLAIN, BE SPECIFIC):

MEDICATIONS BEING TAKEN: _____

EpiPen: Self-carry at all times Inhaler: Self-carry at all times Diabetes: Insulin Pump

If a student athlete participating in intramural or interscholastic events will be carrying their (1) inhalant medications prescribed to treat respiratory conditions or (2) medication administered with a cartridge injector for students with a medically diagnosed allergic condition which may require prompt treatment to protect the student against serious harm or death, be sure to have the prescriber's **self-administration authorization box checked** on the student's MDI or EpiPen Medication Administration Authorization Form. The medication forms are available from the School Nurse or online on the SPS web site at <http://www.southingtonschools.org/admin.cfm?tab=1> under *Medication Administration Forms*.

HAS STUDENT HAD ANY HEAD INJURIES? Yes No HOW MANY: _____ WHEN: _____

Has anyone in your family died suddenly before age 60? Yes No If Yes, Please explain: _____

PART B: PARENT PERMISSION

I give permission for _____ to participate in the sport of _____. I assume all responsibility for notifying the school of any change in my child's health both before and during participation in any sport(s). Students who have been screened by their physician will be excused from school postural screening unless parental request has been made to the school nurse. I hereby give permission for the provision of emergency medical treatment for my child in the event of injury or illness that occurs during participation in school sponsored activities.

SIGNATURE OF PARENT/GUARDIAN _____ **DATE** _____