INK ONLY

PRESS FIRMLY

POUGHKEEPSIE CITY SCHOOL DISTRICT
INTERSCHOLASTIC ATHLETICS
EMERGENCY INFORMATION

SPORT _____

LEVEL: Varsity/JV/ Modified Year: 20 /20

Student # _____

Student Name: _____ Birth Date: _____ Grade: ____
Last First

Home Address: _____ Home Phone: _____

Parent/Guardian: _____ Best Contact No.: _____

Parent/Guardian: _____ Best Contact No.: _____

Alternative Contact: _____ Telephone: _____

Family Physician: _____ Phone: _____

Insurance Company: _____ Insurance #_____

Hospital: _____ Phone: _____

PARENT/GUARDIAN/ ATHLETE AGREEMENT & CONSENT TO MEDICAL TREATMENT

I certify that our athlete is an enrolled student in the City of Poughkeepsie School District and that all information provided is correct. We the undersigned have read, understand and agree to abide by the policies and procedures contained in the PCSD Interscholastic Student Handbook and the NYS mandated concussion policy on www.poughkeepsieschools.org. I am aware that medical expenses resulting from an injury during sport must first be submitted to your own insurance carrier. Any remaining balance can be submitted to the school's accident insurance carrier by processing a claim by processing a claim form that can be obtained from the school. I am also aware that should my athlete wear contact lens PCSD insurance company does not cover any lost or damaged lens. I agree that I am financially responsible for any equipment issued to my athlete.

In the event that my child needs medical attention, I give my consent after making reasonable attempts at the telephone numbers provided, I give consent for the School Principal or designee, or in his/her absence the School Nurse, or in both of their absences the athletic trainer or the coach of an athletic team, to authorize emergency medical and/or hospital personnel to provide emergency and/or non-emergency treatment to my child if injured during a school sponsored event in which he/she participated. Such authorization includes the consent to: contact the family health care provider at the number provided, any x-ray exam, anesthetic, diagnostic test, blood transfusion, medical or surgical treatment and hospital care to be rendered to my child under the general or special supervision and on the advice of any physician or surgeon licensed to practice in the State of New York. Furthermore, I give permission for the school district to contact my child's primary healthcare provider for the purpose of clarifying/obtaining immunization records, health appraisal, medication orders and/or pertinent medical information.

X _____ X _____
Signature of Parent/Guardian Date Signature of Student-Athlete Date

DISTRICT USE ONLY:
TO BE COMPLETED BY SCHOOL NURSE

MEDICAL CLEARANCE CARD

Current Physical Exam Date _____ Interval Health History _____ Parent/Guardian Permission _____

ALLERGY _____ ASTHMA_____

EPI-PEN _____ INHALER_____

RESTRICTIONS/MEDICAL CONDITIONS: _____

_____

SPORT RESTRICTIONS/ACCOMMODATIONS: _____

_____ _____
Signature of School Nurse Date

FINAL APPROVAL-STUDENT APPROVED FOR PARTICIPATION **_____A.D.**
INITIALS

Revised 5/2018 TOP-COACH MIDDLE-AD BOTTOM-HO