Duanesburg Athletic Card

Athlete Last Name: _____ First Name: _____

Address: _____

Phone Number: _____ Grade: _____ Sex: _____ Age: _____ D/O/B: _____

Parent/ Guardian Name: _____

Primary Phone: _____ Emergency Contact_____ Phone: _____

Sport: _____ Level: _____ Year of Graduation: _____

Grade 7 and 8 ONLY

If you would like to try out for JV or Varsity sport, you must pass select classification. This requires additional forms:

1. **Parental Permission signed and returned to AD**
2. **Tanner Scale Form completed by physician (if not listed on physical form)**
3. **Select Classification fitness tests**
4.

Parent / Guardian Signature: _____

Parent / Guardian

I have read the Athletic Code of Conduct, Academic Eligibility and the DCS Student Handbook and understand the regulation, policies, training rules, expected conduct and consequences for failing to follow these, as outlined by NYSPHAA and DCS. I have read and reviewed these Code of Conduct and Student Handbook with my son / daughter and I give permission for _____ to participate in _____.

Parent / Guardian: _____ Date: _____

Student Athlete

I have read the Athletic Code of Conduct, Student Handbook and Athletic Academic Eligibility and understand the academic requirements, polices, training rules and expected conduct of a student athlete at DCS. I agree to comply with the terms and conditions set forth and understand the consequences if I fail to do so.

Athlete signature: _____ Date: _____

Emergency Medical Authorization

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

Family Physician: _____ Phone: _____

Family Dentist: _____ Phone: __ _____

CONSENT OF PARENT OR GUARDIAN FOR EMERGENCY TREATMENT: In the event that reasonable attempts to contact me have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by the above listed doctors or in the event the designated preferred doctor is not available by another licensed physician or dentist and be transferred to _____ or any hospital reasonable accessible.

Parent / Guardian Signature: _____ Date: _____

THIS AUTHORIZATION DOES NOT COVER MAJOR SURGERY UNLESS THE MEDICAL OPINIONS OF TWO LICENSED PHYSICIANS OR DENTISTS, CONCURRING IN THE NECESSITY FOR SUCH SURGERY ARE OBTAINED PRIOR TO THE PERFORMANCE OF SUCH SURGERY. THIS AUTHORIZATION ALLOWS RELEASE OF PERTINENT MEDICAL INFORMATION TO COACHES AND ATHLETIC TRAINERS.

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

_____

_____

_____

Parent / Guardian Signature: _____Date: _____

Note: The school district is not responsible for contact lenses/glasses that are displaced or damaged.

ELIGIBLE FOR PARTICIPATION

The student has met the physical examination requirements approved by the school physician and is eligible to

participate in _____ as of _____.
Level /Sport Date

School Nurse Authorization: _____ Date: _____