# Bella Vista Track and Field Rules Guide Sign-off

PLEASE FILL OUT THE PAGE BELOW. MAKE SURE THAT YOU AND YOUR PARENTS OR GUARDIAN SIGN IT AND RETURN THIS PAGE TO THE HEAD TRACK COACH IN ORDER TO RECEIVE YOUR UNIFORM.

We have read and agreed to abide by the rules set forth for the Bella Vista High School boys track and field program. We also acknowledge that there are certain inherent risks involved in participation in track and field competition as an athlete or as an official or a volunteer; We are aware that by signing this document that we freely agree to take such risk.

Date _____

Athlete's Name: _____

Athlete's Signature: _____

Parent or Guardian's Name: _____

Home Address: _____

_____

Home Phone Number: _____

E-mail Address: _____

Parent or Guardian's Signature: _____

## EMERGENCY INFORMATION
San Juan Unified School District

Grade _____ Room _____
Teacher/Counselor _____
Walk _____ or Bus # _____

NAME CHILD USES:

_____ ❑ Male ❑ Female
*Last* *First*

Child's full legal name: _____ Birthdate: _____
*Last* *First* *Middle*

Home Phone: _____ Address: _____
*No.* *Street* *Apt.* *City* *Zip*

Cell Phone _____ Email Address (Optional) _____

Parent(s) or Guardian child lives with:

If Parents are divorced or separated, to whom has physical custody been granted? (attach verification)

Father: _____ Check One: ❑ Natural ❑ Step ❑ Guardian/Foster ❑ Other Parent

Employer: _____ Business Phone: _____

Mother: _____ Check One: ❑ Natural ❑ Step ❑ Guardian/Foster ❑ Other Parent

Employer: _____ Business Phone: _____

If my child is ill, has an emergency, or is suspended and I cannot be reached, please call and release my child to:

Name: _____ Phone: _____

Check one: ❑ Day Care Provider ❑ Neighbor ❑ Friend ❑ Relative ❑ Other: _____

Name: _____ Phone: _____

Check one: ❑ Day Care Provider ❑ Neighbor ❑ Friend ❑ Relative ❑ Other: _____

Physician's Name: _____ Medical Coverage by: _____ ID#: _____

Address: _____ Physician's Phone: _____ Hospital Preference: _____

**PARENT MUST CHECK ONE**

❑ 1. In the event of an emergency, when a parent or guardian is unavailable, I authorize school personnel to make arrangements for my child to receive medical/hospital care, including necessary transportation, in accordance with their best judgment. I authorize the physician named above to undertake such care and treatment as is considered necessary. In the event said physician is unavailable, I authorize such care and treatment to be performed by a licensed physician or surgeon. I agree to pay all costs incurred as a result of the foregoing.

❑ 2. I do not choose the above statement and desire the following action in the event of an emergency: _____

X _____ X _____
*Parent/Guardian Signature* *Date* *Parent/Guardian Signature* *Date*

FORM #105971 REV 5/04

**TURN CARD OVER AND COMPLETE HEALTH INFORMATION**

FORM #105971 REV 5/04

## PLEASE CHECK THE FOLLOWING ITEMS IF THEY PERTAIN TO YOUR CHILD

### VISION:

❑ Wears glasses ❑ To be worn at all times

❑ Wears contacts ❑ To be worn at all times

❑ Requires preferential seating

Date of last eye exam: _____

Under care of Dr. _____ Phone: _____

Comments: _____

### HEARING:

❑ Has a hearing problem ❑ Has tubes in ears ❑ Uses hearing aid

❑ Requires preferential seating

Under care of Dr. _____ Phone: _____

Comments: _____

### PLEASE READ AND SIGN

"I authorize the release of my child's medical information (1) by the school district and the provider of services to the billing agent and (2) by the school district to my insurance carrier as necessary to process a claim or to request payment of Medical Assistance Benefits. Shared information will be limited to health service documentation only."

_____

Parent/Guardian Signature Date

_____

Print Name Relationship

### HEALTH CONCERNS:

1. Has the following condition(s):

❑ Asthma ❑ Seizures ❑ Migraines ❑ Diabetes

❑ Hyperactive (ADHD) ❑ Heart condition

❑ Allergies (describe): _____

_____

❑ Allergic reaction to bee stings (describe): _____

_____

❑ Other: _____

Are any of the above life threatening? ❑ yes ❑ no (explain): _____

_____

2. List medication prescribed: _____

Current dosage: _____

For (diagnosis): _____

Prescribed by Dr. _____ Phone: _____

Does the drug need to be taken during school hours? ❑ yes ❑ no

"Medication in School" form on file (renew annually) ❑ yes ❑ no

3. Has a physical condition which limits participation in:

❑ Classroom activities ❑ Physical education

(Please explain): _____

_____

Under care of Dr. _____ Phone: _____

4. School of former attendance: _____

City: _____ State: _____