



NAME \_\_\_\_\_ SPORT \_\_\_\_\_

MALE/FEMALE \_\_\_\_\_ HOMEROOM \_\_\_\_\_ CURRENT SCHOOL YEAR \_\_\_\_\_

CONTACT TELEPHONE NUMBER \_\_\_\_\_

PARENT'S EMAIL ADDRESS \_\_\_\_\_

Please **circle the grade levels** that you participated in this sport (including this season):

7      8      9      10      11      12

**FOR STUDENTS IN GRADES 9 – 12 ONLY:** How many semesters have you been in school beyond 8<sup>th</sup> grade (including this semester and based on a **max of 2 semesters** per year)?

(Circle One Number)      1      2      3      4      5      6      7      8

**STUDENT**

I am aware that playing or practicing to play/participate in any sport can be a dangerous activity involving many risks of injury. I understand that the dangers and risks of playing or practicing to play/participate include but are not limited to death, serious neck injury and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to virtually all internal organs, bones, joints, ligaments, muscles, tendons and other aspects of the muscular-skeletal system, and other serious injury or impairment to other parts of my body, general health and well being.

Because of these dangers of participation in the above sport, I recognize the importance of following coaches' instructions regarding playing techniques, training and team rules, and agree to follow such instructions. I further agree to abide by the rules, regulations and other material contained in the Bethel Park Athletic Handbook.

As a result of the Bethel Park School District (BPSD) providing me the opportunity to try out for the above sport and to engage in all activities related to the team, including but not limited to trying out, practicing or playing/participating in that sport, I hereby assume all the risks outlined above.

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date

**PARENT / LEGAL GUARDIAN**

As the parent/legal guardian of the above named student, I have read the STUDENT section above and understand that all sports can involve risk of injury including but not limited to those risks outlined above. As a result of the BPSD providing my child/ward the opportunity to try out for the above named sport and to engage in all activities related to the team, I hereby give my permission for him/her to participate in that sport for the school year indicated.

I understand that the BPSD does not provide medical insurance coverage for its athletes and that our child must be enrolled in some type of medical insurance coverage before participating in interscholastic athletics. We also agree not to hold the BPSD, its officers or its employees, liable for any medical or hospital care or expense. Therefore, I am responsible for any medical care and all related expenses for my child which resulted from any cause whatsoever in connection with the sport listed above.

I understand that as a parent/legal guardian, I am financially responsible for any lost or non-returned school issued uniform/equipment. It is important that all items be returned or paid for so that the following year's team may receive the same benefits of representing their school during athletic contests. Failure to comply will result in the student's name appearing on the school's Obligation List.

\_\_\_\_\_  
Signature of Parent / Legal Guardian

\_\_\_\_\_  
Date

**SECTION 7: RE-CERTIFICATION BY PARENT/GUARDIAN**

This form must be completed not earlier than six weeks prior to the first Practice day of the sport(s) in the sports season(s) identified herein by the parent/guardian of any student who is seeking to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in all subsequent sport seasons in the same school year. The Principal, or the Principal's designee, of the herein named student's school must review the SUPPLEMENTAL HEALTH HISTORY.

If any SUPPLEMENTAL HEALTH HISTORY questions are either checked yes or circled, the herein named student shall submit a completed Section 8, Re-Certification by Licensed Physician of Medicine or Osteopathic Medicine, to the Principal, or Principal's designee, of the student's school.

**SUPPLEMENTAL HEALTH HISTORY**

Student's Name \_\_\_\_\_ Male/Female (circle one)

Date of Student's Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age of Student on Last Birthday: \_\_\_\_ Grade for Current School Year: \_\_\_\_

Winter Sport(s): \_\_\_\_\_ Spring Sport(s): \_\_\_\_\_

**CHANGES TO PERSONAL INFORMATION** (In the spaces below, identify any changes to the Personal Information set forth in the original Section 1: PERSONAL AND EMERGENCY INFORMATION):

Current Home Address \_\_\_\_\_

Current Home Telephone # ( ) \_\_\_\_\_ Parent/Guardian Current Cellular Phone # ( ) \_\_\_\_\_

**CHANGES TO EMERGENCY INFORMATION** (In the spaces below, identify any changes to the Emergency Information set forth in the original Section 1: PERSONAL AND EMERGENCY INFORMATION):

Parent's/Guardian's Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Emergency Contact Telephone # ( ) \_\_\_\_\_

Secondary Emergency Contact Person's Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Emergency Contact Telephone # ( ) \_\_\_\_\_

Medical Insurance Carrier \_\_\_\_\_ Policy Number \_\_\_\_\_

Address \_\_\_\_\_ Telephone # ( ) \_\_\_\_\_

Family Physician's Name \_\_\_\_\_, MD or DO (circle one)

Address \_\_\_\_\_ Telephone # ( ) \_\_\_\_\_

**SUPPLEMENTAL HEALTH HISTORY:**

Explain "Yes" answers at the bottom of this form. Circle questions you don't know the answers to.

- |  |  |
|--|--|
| <p>1. Since completion of the CIPPE, have you sustained an illness and/or injury that required medical treatment from a licensed physician of medicine or osteopathic medicine? <span style="float: right;">Yes No</span></p> <p align="right"><input type="checkbox"/> <input type="checkbox"/></p> | <p>4. Since completion of the CIPPE, have you experienced any episodes of unexplained shortness of breath, wheezing, and/or chest pain? <span style="float: right;">Yes No</span></p> <p align="right"><input type="checkbox"/> <input type="checkbox"/></p> |
| <p>2. Since completion of the CIPPE, have you had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury? <span style="float: right;">Yes No</span></p> <p align="right"><input type="checkbox"/> <input type="checkbox"/></p>   | <p>5. Since completion of the CIPPE, are you taking any NEW prescription medicines or pills? <span style="float: right;">Yes No</span></p> <p align="right"><input type="checkbox"/> <input type="checkbox"/></p>  |
| <p>3. Since completion of the CIPPE, have you experienced dizzy spells, blackouts, and/or unconsciousness? <span style="float: right;">Yes No</span></p> <p align="right"><input type="checkbox"/> <input type="checkbox"/></p>  | <p>6. Do you have any concerns that you would like to discuss with a physician? <span style="float: right;">Yes No</span></p> <p align="right"><input type="checkbox"/> <input type="checkbox"/></p>   |

#s	Explain "Yes" answers here:

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Student's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_