FEDERAL WAY PUBLIC SCHOOLS
INTRAMURAL/ELEMENTARY TRACK PERMISSION FORM

____

Student Name   Date of Birth   Grade   School   Age*

____

Address   City   State   Zip   Phone

Please permit __________________________________to participate in the intramural/elementary track activities program. I understand and acknowledge the following information concerning the programs.

1. The school is unable to provide transportation unless otherwise instructed. Parents will be responsible for picking up those students normally bussed from school. Students normally walking from school may walk home after the program.

2. To get the most from the program, each child should be properly equipped with clothing appropriate for each activity.

3. Because of the strenuous nature of some of the activities, each student should have a physical exam. You should not permit your child to participate in these activities if they are not physically able to participate. Please consult your physician.

4. As the possibility of accident exists, every student is **required** to have accident insurance. An insurance program is offered through Federal Way Public Schools for students who do not have a family policy and wish to obtain coverage (those students with family coverage may purchase this additional insurance if they wish); forms are available in the school office.

I ACCEPT FULL RESPONSIBILITY FOR THE COST OF TREATMENT FOR ANY INJURY MY CHILD MAY SUFFER WHILE PARTICIPATING IN THE SCHOOL DISTRICT'S INTRAMURAL/ELEMENTARY TRACK PROGRAM.

____   __________________________

Parent/Guardian Signature   Date

* As of March 1 of competing year.

MUST BE COMPLETED BEFORE FIRST PRACTICE
MEDICAL EMERGENCY AUTHORIZATION FORM
To be completed by parent or guardian and returned to the coach.

Name of Student Athlete:______________________________________ M ______ F ______ Student ID# _____________
Address ____ DoB________________________ Grade__________

As parent or legal guardian, I authorize the team physician or, in his/her absence, a qualified physician to examine the above-named student; and in the event of injury to administer emergency care and to arrange for any consultation by a specialist, including a surgeon, he/she deems necessary to insure proper care of any injury. Transportation will be arranged if deemed necessary by school or emergency personnel. Every effort will be made to contact the parent or guardian to explain the nature of the problem prior to any involved treatment or transportation.

Name: ____ Date: _____________________________
(Parent or guardian)
Parent/Guardian signature: ____
Home Phone: ( )__________________________________ Business Phone: ( )____________________________
( )__________________________________ ( ) ____________________________

Secondary Emergency Contact Person:

Name: ____ Phone: ( )____________________________

Family Physician's Name: ______________________________________ Phone: ( )____________________________

Hospital Preference: ____
Insurance company: ____ Policy number: __________________________

Student Medical History

Yes No

1. ___ ___ Are you allergic to any medication?Which?____
2. ___ ___ Do you take any medication regularly? Which?____
3. ___ ___ Do you have any chronic or recurrent illnesses Which?______________________________________
4. ___ ___ Have you ever been hospitalized? When? _______________Reason?_________________________
5. ___ ___ Have you ever required an operation? When? ____________Reason?_________________________
6. ___ ___ Have you ever had a concussion? When? _______________Reason?__________________________
7. ___ ___ Have you had a tetanus shot within the last 5 years? Date of last shot: _________________________
8. ___ ___ Do you wear glasses or contact lenses? (circle)
9. ___ ___ Do you wear any dental appliance such as a bridge, plate or braces? (circle)
10.___ ___ Have you ever had asthma or breathing difficulties? Medication? ______________________________
11.___ ___ Do you have any organs missing other than tonsils or appendix (eye, kidney, testicle, etc.)? ___________________
12.___ ___ Are you allergic to bee stings or other insect bites? What procedure should the school staff follow if this should occur?
____
13.___ ___ Are you currently taking ANY medications? (Including vitamins, aspirin, etc.)What?_______________________