

2022 - 2023

IDA CROWN HIGH SCHOOL ATHLETICS PERMIT CARD

A new form must be submitted each school year to the Athletic Director prior to the first day of practice

Circle the sports you are interested in participating

Boys: X-Country – Basketball – Baseball – Fencing - Wrestling

Girls: X-Country – Basketball – Fencing - Soccer

PLEASE PRINT IN INK

Name _____
Last First Middle

Address _____ City _____ Zip _____

Phone _____ / Email: _____

IN EMERGENCY CALL

(If Mother/Father/Guardian not available)

Name _____

Home & Cell #'s _____

Permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, x-ray, examination and immunizations for the above named student. In the event an emergency occurs due to serious illness, a need for major surgery, or a significant accidental injury, I understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If said physician is not able to contact me, the treatment necessary for the best interest of the above named student may be given. Permission is also granted to the athletic trainer to provide the needed emergency treatment prior to the student's admission to medical facilities, as well as administration of daily medical, rehabilitative treatments of an acute/chronic athletic injury. _____ **Initials**

PARENT PERMISSION / ATHLETIC RISK WARNING AGREEMENT

We advise all athletes to be adequately covered by hospitalization insurance. Your signature on this form indicates that you will accept financial responsibility in case of injury to your child sustained in connection with these sports.

If my child is interested in trying out for any of our sport programs, I understand that an updated physical is required prior to the first day of activity.

No student-athlete may participate in IHSA competition unless the student and the student's parent/guardian consent to a random testing of performance enhancement drugs.

I have read, understand and agree to abide by the code of ethics & conducts, communication plan, bus policy and IHSA policies as stated.

Date: _____ **Athlete Signature:** _____

Our son/daughter has our permission to practice and compete in the interscholastic athletic program. We realize that such activity may involve the potential for injury.

Date: _____ **Parent / Guardian Signature:** _____

PHYSICIAN'S EXAMINATION

I have examined this student on the date below and find him/her to be physically fit for athletics' participation.

_____ M.D.

Physician's signature or signature stamp required

Date of athlete's most recent physical

PHYSICAL IS VALID FOR ONE CALENDAR YEAR ONLY