Mount Arlington Public School District
235 Howard Boulevard
Mt. Arlington, NJ 07856

(973) 398-4400 Fax (973) 770-1568

Name_____ Male ____ Female ___ DOB_____
Address_____
Athlete lives with (circle): both parents mother father guardian
Sport_____
Grade_____

Mother's Name_____ Home Phone_____
Cell_____ Work_____

Father's Name_____ Home Phone_____
Cell_____ Work_____

Emergency Contacts:
Name_____ Home Phone_____
Cell_____ Work_____
Name_____ Home Phone_____
Cell_____ Work_____

Family Doctor _____ Phone_____
Dentist_____ Phone_____
Medical Insurance _____ Policy #_____

I give permission for my child's participation in the indicated sport for the 20____ season and to accompany the team on scheduled athletic trips. All athletes are covered by school insurance, which is an excess policy that can be used only after the family health insurance has been used. Please note that the rules of the New Jersey Board of Education require that the school district advise you, as a parent/guardian, of the possibility of physical hazards to your child.

I give permission to share medical information as needed with the appropriate personnel. I give consent for coaches, trainers and the team physician to use their own judgments in the application of first aid treatment and in securing medical aid and ambulance service as necessary.

Your signature is acknowledgement of notification and approval to participate.

_____ _____ _____
Parent/Guardian Signature Student Signature Date

++

(OFFICE USE ONLY)
PE Date_____
Asthma_____ Medication/Inhaler_____
Allergies: Life Threatening _____ Benadryl_____ EpiPen _____
Medication_____
Medications currently taking _____
Chronic/Ongoing Medical Conditions_____
Cardiac Conditions_____
Protective Equipment needed_____
Neurological Conditions/Concussion_____
Other _____
Glasses_____ Contacts_____

AD Signature_____ RN Signature _____
Date_____ Date_____