

**ARCHBISHOP CARROLL HIGH SCHOOL  
PERMISSION FOR ATHLETIC PARTICIPATION AND EVALUATION**

STUDENT'S NAME \_\_\_\_\_ GRADE \_\_\_\_\_

**STUDENT PARTICIPATION AND PARENTAL APPROVAL**

Involvement in high school athletics entails a number of rewards, but also carries potential physical risks. Some of these risks include, but are not limited to ligament sprains, muscle strains, cartilage damage, neck or head injury, and fractures. I understand that sports involve the risk of serious injury or death. This is to acknowledge that Archbishop Carroll High School assumes no responsibility for known risks associated with the voluntary participation in school organized athletics. I understand the extreme importance of following all coaches' instructions regarding playing technics, training guidelines, and team rules. Being fully aware of and taking responsibility for these risks, I grant my child permission to participate in tryouts, practices, and competitions. In addition to this, I waive any claim by me, my spouse, or my child against Archbishop Carroll High School and its employees arising from a sports related injury or from transportation to/from a sporting event.

Archbishop Carroll High School's insurance coverage does not include personal injury sustained as a result of athletic participation. It is necessary to make sure that your child is covered by your own policy in order to participate in sports at school. If health insurance is not provided by the athlete's family policy, the student is not eligible to participate on school interscholastic athletic teams.

\_\_\_\_\_  
Print name of Parent/Guardian

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

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date

**PERMISSION TO TREAT**

- I Permission is granted to Archbishop Carroll High School Certified Athletic Trainers, Faculty, and coaches to proceed with the necessary primary and secondary first aid procedures if the situation should call for it. In the event of serious illness or injury, it is understood ACHS personnel will first try to contact those designated as emergency contacts. In the event no one can be reached, I give permission for ACHS personnel to take my child emergency care center, or an available physician to obtain the necessary treatment.
- II Permission is granted to the ACHS Certified Athletic Trainer to evaluate, perform minor medical treatment, and/or rehabilitate injuries for the above mentioned athlete. In the treatment of injuries, I allow the use of modalities that the Certified Athletic Trainer is competent with and qualified to use (i.e. ice, moist heat, ultrasound electric stimulation, T.E.N.S. and paraffin bath).
- III Permission is granted to the ACHS Certified Athletic Trainer to distribute oral and topical medications (listed below) to the above named student. Please indicate any medications your son/daughter SHOULD NOT be given

- |                                                                          |                                                                         |                                                             |
|--------------------------------------------------------------------------|-------------------------------------------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> Acetaminophen (Tylenol or generic)              | <input type="checkbox"/> Calcium Carbonate (Antacid)                    | <input type="checkbox"/> Medi-Lyte (electrolytes)           |
| <input type="checkbox"/> Anti-fungal Cream/Powder (Tinactin or generic)  | <input type="checkbox"/> Diphenhydramine (Benadryl (allergy or generic) | <input type="checkbox"/> Mentho-luptus (Halls or generic)   |
| <input type="checkbox"/> Bacitracin                                      | <input type="checkbox"/> Flexall (analgesic / Ice Hot)                  | <input type="checkbox"/> Multi-vitamin                      |
| <input type="checkbox"/> Benzoin Tincture (adherent)                     | <input type="checkbox"/> Hydrocortisone                                 | <input type="checkbox"/> Naproxen Sodium (Aleve or generic) |
| <input type="checkbox"/> Betadine                                        | <input type="checkbox"/> Hydrogen Peroxide                              | <input type="checkbox"/> NitroTan (Wound cleaner)           |
| <input type="checkbox"/> Biofreeze (analgesic)                           | <input type="checkbox"/> Ibuprofen (Advil or generic)                   | <input type="checkbox"/> Sterile Saline Solution            |
| <input type="checkbox"/> Bismuth Subsalicylate (Pepto Bismol or generic) | <input type="checkbox"/> Loperamide Hydrochloride (Antidiarrheal)       | <input type="checkbox"/> Tuffskin (Adherent Spray)          |

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

\_\_\_\_\_  
Date

## Health and Emergency Information

1. It is being requested that all students complete the attached information on an annual basis and return it to school on or before September 1.
2. Student athletes must have the highlighted area on page one checked and the Permission Participation and Evaluation form completed. No student will be permitted to engage in Sports unless ALL attached documents are completed in full and signed by both a Parent/guardian and a physician.

NAME \_\_\_\_\_ GRADE \_\_\_\_\_ GENDER \_\_\_\_\_

MOTHER/GUARDIAN \_\_\_\_\_ WORK PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_

\_\_\_\_\_ CELL PHONE \_\_\_\_\_

FATHER/GUARDIAN \_\_\_\_\_ WORK PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_

\_\_\_\_\_ CELL PHONE \_\_\_\_\_

EMERGENCY CONTACT NAME \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

LIST KNOWN MEDICAL PROBLEMS PERTINENT IN AN EMERGENCY (Diabetes,  
Asthma, Anemia, Epilepsy, etc.) \_\_\_\_\_

MEDICATIONS TAKEN ON A REGULAR BASIS \_\_\_\_\_

ACHS personnel have permission to transport my child to the hospital or available physician and to provide needed medical services. Permission is granted to the hospital and its' physicians and staff to proceed with any medical or minor surgical treatment or x-rays needed for my child. In the event of serious illness or significant injury where major surgery is necessary, I understand an attempt will be made to contact me. In the event I cannot be reached, the treatment necessary for the best interest of my child is to be given.

\_\_\_\_\_  
Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

### INSURANCE INFORMATION

Insurance Company Name \_\_\_\_\_ Phone # \_\_\_\_\_

Company Address \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ Policy # \_\_\_\_\_

Authorization to release benefits to medical center/physician

\_\_\_\_\_  
Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_