

**2009-2010 Lake Washington School District No. 414
INTERSCHOLASTIC ATHLETICS REGISTRATION**

ASB Fee Paid: _____
Sport Fee Pd: S1 S2 S3 S4
Family Pd: _____

Student's name _____ Date of Birth _____

Sex: Male Female (Last) (First) (MI) Grade _____ Home Phone _____

Name of Parent / Guardian _____ Cell/Office Phone _____

Name of Family Physician _____ Office Phone _____

PHYSICAL EXAMINATION / CLEARANCE (Completed by Physician only) Date of original exam _____

| | | | |
|-------------------|--------------------|----------------------------------|----------|
| Medications _____ | Height _____ | Weight _____ | |
| Vision _____ | BP _____ | HR _____ | UA _____ |
| Eyes _____ | GI / GU _____ | Allergies (food/medicines) _____ | |
| Ears _____ | Skin _____ | Musculoskeletal _____ | |
| Nose _____ | Neurological _____ | | |
| Teeth _____ | | | |
| Heart _____ | | | |
| Lungs _____ | | | |

DO YOU KNOW ANY REASON WHY THIS CHILD SHOULD NOT PARTICIPATE IN THE ATHLETIC PROGRAMS IN THE Lake Washington SCHOOL DISTRICT?

No Yes if yes, please explain _____

Today's date _____ Physician's Signature _____

ASSESSMENT: Full Participation Limited Participation (describe limitations below)

Health History: (To be completed by parent / guardian)

| | | | |
|---------------------------------|----------------------------|-----------------------------|----------------------|
| Asthma _____ | Convulsions _____ | Neck or back surgery _____ | Contact lenses _____ |
| Concussion _____ | Heart problems _____ | False teeth or bridge _____ | |
| Epilepsy _____ | Dehydration problems _____ | abnormal bleeding _____ | |
| Sprains/strains/fractures _____ | | | |
| Anything else _____ | | | |
| Current medications _____ | | | |
| Physician's name _____ | Preferred hospital _____ | | |

EMERGENCY CONTACT: (Relative or Neighbor) _____ Phone: _____

Other #'s where in emergency we can reach you _____

INSURANCE INFORMATION: I have medical coverage for doctor's services and hospitalization and will continue to keep it in force throughout the sports season. I accept full responsibility for the cost of treatment for any injury my student may suffer while participating in the athletic program.

Insurance Co. name _____ Policy # _____

MEDICAL AUTHORIZATION: As a parent or legal guardian, I authorize a qualified physician to examine the above named student in the event of an injury to administer emergency care and arrange for any consultation by a specialist, including a surgeon, deemed necessary to ensure proper care of any injury. Every effort will be made to contact the parent or guardian to explain the nature of the problem prior to any involved treatment.

PERMISSION TO SHARE INFO / PHOTOS WITH MEDIA LWSD only Local News None

ATHLETIC, DRUG, ALCOHOL, TOBACCO & CONDUCT CODES: I have read the Lake Washington School District Athletic Codes and will follow the requirements. I hereby give my consent for the student athlete named above to accompany any school team and represent his/her school in athletic events. All the information provided above is correct and true.

Student signature

Parent signature

Date