ASB Fee Paid: ________
Sport Fee Pd:
Jr. High: S1 S2 S3 S4
HS: Fall__ Winter__Spring__
Family Pd : _______

Lake Washington School District No. 414

INTERSCHOLASTIC ATHLETICS REGISTRATION

Student's name ____ Date of Birth _______________
(Last) (First) (MI)

Sex: ☐ Male ☐ Female 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 ____
Vision ____________________________ Height________________ Weight________________
Eyes ______________________________ BP ____________ HR __________ UA _______________
Ears ______________________________ GI / GU ____
Nose ______________________________ Allergies (food/medicines) ___________________________
Teeth _____________________________ Skin ____
Heart _____________________________ Musculoskeletal ____________________________________
Lungs _____________________________ Neurological ______________________________________

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 & HAZING 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