

Lake Washington School District No. 414
INTERSCHOLASTIC ATHLETICS REGISTRATION

ASB Fee Paid: _____
Sport Fee Pd: _____
Jr. High: S1 S2 S3 S4
HS: Fall__ Winter__ Spring__
Family Pd : _____

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