CAPITAN MUNICIPAL SCHOOLS

EMERGENCY INFORMATION, APPROVAL FOR EMERGENCY TREATMENT, & STATEMENT OF INSURANCE COVERAGE

Student Name:___________________________________ Age_______ Grade________

Sports you expect to participate in:

Football__________ Basketball_________ Track_________ Volleyball_______ Golf_______

Baseball__________ Softball________ Cheerleading________

Parent/Guardian Name:____

Address____ Telephone Number_________________________

Cell Number______________________________

Emergency Telephone______________________________

Family Physician___________________________________ Telephone_______________________________

Family Dentist_____________________________________ Telephone_______________________________

Parent / Guardian Approval for Emergency Treatment

I hereby give permission to the coaching staff of Capitan Municipal Schools to admit my son / daughter to a hospital or to place my son / daughter under a physician's care in an emergency situation if I cannot be reached to give my consent.

Date:________________ Signature of Parent / Guardian_______________________________________

Statement of Insurance Coverage

I,____, have the following health and accident insurance which I consider to be sufficient to cover all claims arising from any injury which my son / daughter may experience while participating on any athletic team of the Capitan Municipal Schools, and I will not hold the Capitan Municipal Schools responsible for payment of any medical treatment of such injury. (Photo Copy of Insurance Card Needed)

Insurance Company________________________________ Policy Number___________________________

Date_________________ Signature of Parent / Guardian____________________________________

And / or

We have applied for Student Accident Insurance for Football______________ Other School Sports____________

__________ 24 Hour Coverage (Does not include Football)

CAPITAN MUNICIPAL SCHOOLS

WARNING, ASSUMPTION OF RISK, RELEASE
AGRREMENT TO OBEY INSTRUCTIONS, &
PARENT APPROVAL FOR PARTICIPATION

BOTH STUDENT AND PARENT / GUARDIAN MUST READ AND SIGN THE FOLLOWING

I, ____, am aware that athletics, whether playing or participating to play, may involve risks of injury, I understand that dangers and risks of playing or practicing to play athletics include but are not limited to death, serious neck injury and spinal injuries which may result in complete paralysis, brain damage, serious injury or virtually all bones, joints, ligaments, other aspects of the muscular skeletal system, and serious injury or impairment to other aspects of my body, general health and well-being. I understand that the dangers and risks of playing and practicing to play in athletic contests may result not only in serious injury, but may also result in serious impairment of my future abilities to earn a living, to engage in other business, social and recreational activities and generally to enjoy life. Because of the dangers of athletics, I recognize the importance of following coaches' instructions regarding playing techniques, training, and other team rules etc, and I agree to obey such instructions and rules. In consideration of the Capitan Municipal Schools permitting me to try out for the Capitan High / Middle School athletic teams and to engage in all activities related to the teams, including, but not limited to trying out, practicing or playing athletics. I hereby assume all risks associated with athletics and agree to hold Capitan Municipal Schools, its employees, agents, representative, coaches and volunteers harmless form any and all liability, actions, causes of actions, debts, claims or demands of any kind and nature whatsoever which may arise by or in connection with my participation in any activities to the Capitan High School or Capitan Middle School athletic teams. The terms hereof shall serve as a release and assumption of risks for me, my heirs, estate, executor / administrator, assignees, and for all member of my family.

Signature of Student__________________________________ Date______________________________

I,____, as the Parent / Legal Guardian of

____, have read the above Warning, Assumption of Risk, Release, Agreement to Obey Instructions, and Parent Approval for Participation and understand the terms. I understand that athletics are contact sports involving many risks of injury. By Capitan Municipal Schools permitting my child/ward to try out for the Capitan High / Middle School athletic team and to engage in all activities related to the team, including, but not limited to tryout out, practicing, or playing athletics. I hereby agree to hold the Capitan Municipal Schools, its employees, agents, representative, coaches, and volunteers harmless from any liability, actions, causes of action, debts, claims or demands of every kind and nature whatsoever which may arise by or in connection with participation of my child/ward in any activities related to Capitan Middle School or Capitan High School athletic teams. The terms hereof shall serve as a release for me, my heirs, estate, executor / administrator, assignees and for all members of my family.

Signature of Parent/Guardian___________________________________ Date_____________________________

CAPITAN MUNICIPAL SCHOOLS
MEDICAL HISTORY FORM
PERSONAL MEDICATON NOTIFICATION, &
PARENTAL CONSENT FOR RELEASE OF INFORMATION TO NMAA

MEDICAL HISTORY

Parents please note: The following Medical History questionnaire must be completed before your student meets with your physician for the Medical Exam, and must be given to the physician at the time of the examination. Please assist you child in completion of this form:

Student Name:_________________________ Date of Birth___________________ Grade__________

Name of Parent:____

Address:____

Telephone: Home________________________ Parent Cell_________________ Emergency_____________

Please answer YES or NO to the following questions: Have you or anyone in your family had, or now have the following:

	Parent Yes/No	Student Yes/No		Parent Yes/No	Student Yes/No
Diabetes			Allergies		
Hay Fever			Asthma		
Migraine Headaches			Heart Trouble		
High Blood Pressure			Skull Fracture		
Tendency to Lose Consciousness			Convulsion or Epilepsy		
Neck Injury			Very Bad vision/one eye		
Temporary loss of vision			Wear Glasses/contacts		
Hearing Loss			Perforated ear drum		
Orthodontia			Sinus Infections		
Kidney Problems			Dental Plate		
Joint Dislocation			Hernia		
Bone Infection			Bone Fracture		
Bee Sting Reaction			Foot Problems		
Anemia			Hives or Rash		
Knee Injury			Tendency to Bleed Easily		
Heart Murmur			Back Injury		
Chest Pain w/Exercise			Other Joint problems		
Dizziness/Faintness/w exercise			Persistent Cough		
Recurrent Skin Infection/Boils			Fungus Infections		
Pins, Staples or wire in any part of your body			Weight Problem: Under_____Over_________		
Boys Loss of Function or Absence of Testicle)			Girls Menstrual Problems Age onset of menstruation____		
Inhaler (Please Specify)					

Are you allergic to any type of medication____________ Please list____
Do you take any medication regularly_____________ Please list____
Do you smoke________
Have you been told to give up sports because of health problems_____________
Has anyone in your family under age of 50 died suddenly____________
*Do you want to talk to the doctor about a health problem or injury___________
*Do you wish to discuss an emotional problem with the doctor_____________

Please list any past history of injuries, operations, illnesses, etc, and include date and doctor providing treatment:

I have reviewed the above medical history of my child and find the answers to the questions to be true and correct to the best of my knowledge.

Parent Signature________________________________ Date_______________________________

Personal Medication Notification

For my protection, I, the student athlete, agree that I will inform the athletic trainer and / or doctors if I am taking any medication of using any ointment, liniments, or balms, or if I have a metal implant in my body before receiving therapy or treatment or any kind in the training room. Any of the above combined with deep heat therapy could cause serious complications.

We the Student Athlete and Parents / Guardians have read and understand the preceding statement and agree to the content.

Signature of Student_________________________________ Date__________________________

Signature of Parent / Guardian__________________________ Date_________________________

Parental Consent for NMAA

I hereby give by consent for my son / daughter ______________________________to participate in interscholastic athletics at Capitan Municipal Schools and authorize Capitan Municipal Schools to provide information from the Medical or Dental sections of this form to the New Mexico Activities Association.

Signature of Parent / Guardian__________________________ Date_________________________________

Student Name:______________________________________

Name of Parent / Guardian_____________________________

Address____

Telephone Number___________________________________

Student Date of Birth______________ **Age**__________ **Gender**___________

Height________________ **Weight**_____________

Blood Pressure__________ **Pulse**_______________

Eyes-Uncorrected R/20 L/20
Eyes-Corrected R/20 L/20

	NORMAL	ABNORMAL	REMARKS
EENT			
Respiratory			
Cardiovascular			
Abdomen			
Hernia			
Genitalia			
Musculoskeletal			
Neurological			
Deformities			
Surgical Scars			
Skin			
Urinalysis(sugar)			

Comments:____

I certify that I have on this date reviewed the Medical History of the above student; have examined this individual and find him/her physically able to compete in Interscholastic Athletics:

Signature of Physician__________________________________

Physician Name-Address & Telephone Number:

Date:____