

CAMAS HIGH SCHOOL

ATHLETIC AND MEDICAL EMERGENCY AUTHORIZATION FORM

Check the box next to the sport you are playing each season. Please put an "M" after the sport if you are going to be a manager. Return this form to the Athletic Office at Camas High School.

- | | | |
|---|--|---------------------------------------|
| FALL | WINTER | SPRING |
| <input type="checkbox"/> Football | <input type="checkbox"/> Boys Basketball | <input type="checkbox"/> Baseball |
| <input type="checkbox"/> Cross Country | <input type="checkbox"/> Girls Basketball | <input type="checkbox"/> Softball |
| <input type="checkbox"/> Boys Golf | <input type="checkbox"/> Wrestling | <input type="checkbox"/> Boys Soccer |
| <input type="checkbox"/> Girls Soccer | <input type="checkbox"/> Boys' Swim | <input type="checkbox"/> Girls Golf |
| <input type="checkbox"/> Volleyball | <input type="checkbox"/> Gymnastics | <input type="checkbox"/> Girls Tennis |
| <input type="checkbox"/> Girls Swim | <input type="checkbox"/> Competitive Dance | <input type="checkbox"/> Track |
| <input type="checkbox"/> Boys Tennis | <input type="checkbox"/> Basketball Cheer | |
| <input type="checkbox"/> Football Cheer | <input type="checkbox"/> Dance | |

Name of Student _____

First
Last
Middle Initial
Grade

- CHS Student Hayes Freedom Private School Home Schooled * Running Start

*If you are home schooled you must show that you are registered with the Camas District Office.

Parent's Name _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Emergency phone other than parent: (Neighbor, Relative, Friend, etc)

Name: _____ Relationship: _____ Phone _____

Name: _____ Relationship: _____ Phone _____

Email Address _____

Health and Dental Insurance is Required by the WIAA for participation in athletics

Health Insurance Provider _____ Policy No. _____

Does your health provider cover dental accidents? _____ yes _____ no

Emergency Dental Provider (If not covered by medical) _____ Policy No. _____

As parent or legal guardian, I authorize the team physician or, in his absence, a qualified physician to examine the above-named student in the event of injury. I also give permission to administer emergency care and to arrange for any consultation by a specialist, including a surgeon if deemed necessary, to insure proper care of any injury. Every effort will be made to contact a parent or guardian to explain the nature of the problem prior to any involved treatment. I have also read the Athletic Code of Conduct and agree that my son/daughter must follow the guidelines set forth.

Parent/Guardian Signature: _____ Date _____

I have read the Athletic Code of Conduct and agree to follow the guidelines set forth.

Student Signature _____ Date _____