

### Niskayuna Central Schools Athletic Card

Athlete- Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
E-mail Address \_\_\_\_\_  
Mailing Address \_\_\_\_\_

Sport \_\_\_\_\_ Level \_\_\_\_\_ Year of grad. \_\_\_\_\_ Homeroom \_\_\_\_\_ Date of birth \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_  
Phone: Home \_\_\_\_\_ Work \_\_\_\_\_  
If in Middle School  Iroquois  Van Antwerp  
 7<sup>th</sup> grade  8<sup>th</sup> grade

Other Parent/ Guardian Name \_\_\_\_\_  
Phone: Home \_\_\_\_\_ Work \_\_\_\_\_

I have read the Parent/ Athlete handbook and understand the guidelines, procedures, conduct, training rules and consequences. I understand that participating in athletic activities implies risk of injury. I give my son/daughter \_\_\_\_\_ permission to participate. I have read and reviewed the rules and regulations with my son/daughter.

\_\_\_\_\_  
Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

I acknowledge that I have read the parent/ Athlete handbook and understand the guidelines, procedures, conduct, training rules and consequences. I agree to comply with the terms and conditions set forth in order that I may participate. (Athletic handbook available on District Page)

\_\_\_\_\_  
Athlete Signature \_\_\_\_\_ Date \_\_\_\_\_

The student has met the physical examination requirements approved by the school physician and is eligible to participate.

School Nurse Authorization \_\_\_\_\_

### Emergency Medical Authorization

Purpose: To enable parents and guardians to authorize emergency treatment for children who become ill or injured while under school supervision, when parents or guardians cannot be reached.

Family Physician \_\_\_\_\_  
Phone \_\_\_\_\_  
Family Dentist \_\_\_\_\_  
Phone \_\_\_\_\_

CONSENT OF PARENT OR GUARDIAN FOR EMERGENCY TREATMENT: in the event that reasonable attempts to contact me have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by the above listed doctors or, in the event the designated preferred doctor is not available, by another licensed physician or dentist and be transferred to: \_\_\_\_\_ or any hospital reasonably accessible.

\_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_

THIS AUTHORIZATION DOES NOT COVER MAJOR SURGERY UNLESS THE MEDICAL OPINIONS OF TWO LICENSED PHYSICIANS OR DENTISTS, CONCURRING IN THE NECESSITY FOR SUCH SURGERY ARE OBTAINED PRIOR TO THE PERFORMANCE OF SUCH SURGERY. THIS AUTHORIZATION ALLOWS RELEASE OF PERTINENT MEDICAL INFORMATION TO COACHES AND ATHLETIC TRAINERS.

Facts concerning the child's medical history including allergies, medication being taken and any physical impairments to which a physician should be alert: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_

Note: the school district is not responsible for contact lenses/glasses that are displaced or damaged.