HALTON CATHOLIC DISTRICT SCHOOL BOARD CDSB

Revised September 2015

INTERSCHOOL ATHLETICS
ACKNOWLEDGEMENT OF RISKS AND CONSENT TO PARTICIPATE FORM

Parents/Guardians are requested to complete the following Consent to Participate and Medical Information Form and return it to the appropriate school personnel.
Note: the student is ineligible to participate in practices or competitions without first providing teacher/coach with both the Consent to Participate and Medical Information Form.

Name of School: _____ Date: _____

Student's Name: _____ Grade/Class/Course: _____

REQUIRED INITIALS/SIGNATURES FOR PARTICIPATION

ACKNOWLEDGEMENT:

I/We hereby acknowledge and accept the risks inherent in the requested activity _____ and assume responsibility for my son's/daughter's/ward's
(name of activity)
personal health, medical, dental and accident insurance. **Initials of parent/guardian** _____

I/We have discussed the identification (signs and symptoms) and management of concussion with our son/daughter based on the HCDSB Concussion protocol and/or Dr. Evans' YouTube video.
Initials of parent/guardian _____
I/We have read and understand the notice of Accident Insurance. **Initials of parent/guardian**_____

BEHAVIOUR CODE:

I am aware that it is a privilege and not a right to participate on a school team. Therefore, I fully understand that it is my responsibility to follow the Board/school/athletic association's Code for Athletes and my school's Code of Conduct and to display good sportsmanship at all times while representing my school as a student athlete.
Signature of student _____ Date _____

BEHAVIOUR AGREEMENT:

I/We agree to pay any damages that may be occasioned through the misconduct or carelessness of our son/daughter/ward to the person or property of the affected party or parties.
Signature of Student: _____ Date: _____
Signature of Parent/Guardian: _____ Date: _____

CONSENT TO PARTICIPATE:

I /We give consent for our son/daughter/ward to try out/participate in the following Interschool athletic activity: _____ during the _____school year.
(name activity)

- Signature of Student: _____ Date: _____
- Signature of Parent/Guardian: _____ Date:_____

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INTERSCHOOL ATHLETICS EMERGENCY CONTACT- MEDICAL INFORMATION FORM

This form must accompany the teacher/coach at all practices and competitions.

STUDENT NAME: _____ **TEACHER:** _____ **GRADE:** _____

EMERGENCY CONTACT: List order to call 1-2-3

_____ Mother's Name: _____ Contact Number(s): _____

_____ Father's Name: _____ Contact Number(s): _____

_____ Emergency Contact Name: _____ Contact Number: _____

CURRENT MEDICAL INFORMATION:
(Where your son's/daughter's/ward's condition is confidential or requires further explanation you are requested to contact your son's/daughter's/ward's coach.)

1. If your son/daughter/ward wears or carries a medic alert bracelet, neck chain or card:
   Please specify what is written on it: _____
   First aid procedures in case of incident: _____
   _____

2. Has your son/daughter previously been diagnosed with a concussion? yes__ no__
   How many times? ___
   When was the last diagnosis? Yr.___ mo.___ date___
   What medical advice was given by a medical doctor/nurse practitioner about participating in future physical activity? _____

3. If your son/daughter/ward has a medical condition (e.g. asthma, anaphylaxis, type 1 diabetes, epilepsy, other) that will affect full participation on the trip, please specify:
   _____
   First aid procedures in case of incident or contact supervising teacher: _____
   _____

4. What medication(s) (prescription and non-prescription) should your son/daughter/ward have with them/take during
   the field trip? _____
   When should the medication be taken? _____
   Who should administer the medication? _____

5. Specify any other physical limitations your son/daughter/ward has that may affect their full participation with
activities. Provide pertinent details or contact supervising teacher: _____

MEDICAL SERVICES AUTHORIZATION - (OPTIONAL SIGNATURE TO PARTICIPATE)
Every reasonable effort will be made by the school/hospital to contact parents/guardians before any medical services are provided. In cases where contact is tried but not made I/we give consent for medical personnel to administer medical and/or surgical services including anaesthesia and drugs.

Signature of Parent/Guardian_____ Date_____

FREEDOM OF INFORMATION NOTICE
The information provided on this form is protected under the Freedom of Information and Protection of Privacy Act and will be utilized only for the purposes related to the Board's policy on Out-of-Classroom Programs.