



Centennial Spin

Name _____ Grade: _____ Date: _____

<p>HEALTH & SAFETY: I have read and understand the Health & Safety Information to include: Parent & Athlete Concussion Information Sheet, AIA Heat Acclimatization & Exertional Heat Illness Management Policy and Hot Weather, Heat Stress, Hazing Policy & School Safety. Information available at www.kyrene.org/Page/1116</p>	<p>Please provide initial: _____</p>
<p>CONSENT/WARNING: I/we give permission for my/our child to participate in organized interscholastic athletics. realizing that such activity involves the potential for injury which is inherent to all sports. I/we acknowledge that when participating in interscholastic athletics, there is an inherent risk of injury, disability, quadriplegia or even death.</p>	<p>Please provide initial: _____</p>
<p>EMERGENCY CONTACT: The following person can answer on your behalf for your child in case of emergency. This person is in addition to the parent/guardian.</p>	<p>Name: _____ Phone: _____</p>
<p>PAYMENT & FEES: I have read, understand and will adhere to the Payment and Fee Agreement.</p>	<p>Please provide initial: _____</p>
<p>HOSPITAL: Please provide name & address. If no preference, please write "no preference".</p>	
<p>DOCTOR: Please provide full name, address and phone number.</p>	<p>Name: _____ Address: _____ _____ Phone: _____</p>
<p>DENTIST: Please provide full name, address and phone number.</p>	<p>Name: _____ Address: _____ _____ Phone: _____</p>
<p>Date of last Tetanus shot.</p>	



Drug Allergies (penicillin, etc.)	
Allergies to insect bites, foods or plants. Please list details and instructions as needed.	
Other Health Concerns	
EMERGENCY SERVICES: In the event of an emergency where I cannot be contacted, I consent to my child being taken to the hospital emergency room at the discretion of school or emergency personnel. I acknowledge that any expense for emergency transportation and/or treatment shall be the responsibility of the parent or legal guardian.	Please provide initial: _____
MEDICAL COVERAGE: I verify that my child will be covered by my medical insurance policy which includes coverage of injury in a school supervised game or activity.	Please provide initial: _____
INSURANCE COMPANY: Please provide name & address.	Name: _____ Address: _____ _____
INSURANCE POLICY NUMBER	
Medical Insurance Phone Number	
Medical Insurance Effective Date	
CHANGE IN MEDICAL COVERAGE: Parents are required to provide the District with immediate notice of any change in the insured status of their student participant.	Please provide initial: _____
VERIFICATION: I have read and verified that the answers above are accurate and up to date.	Please provide initial: _____

Parent or Guardian: _____ Date: _____

Signature: _____