

DOUGLAS COUNTY SCHOOL DISTRICT RE-1

ATHLETIC REGISTRATION/EMERGENCY INFORMATION CARD

School Name: **2011-12**

Castle View High School

\$150.00 ATHLETIC FEE DUE AT REGISTRATION

- CLEARED** FOR PRACTICE
- CLEARED** FOR SCRIMMAGE OR COMPETITION
- NOT CLEARED** FOR SCRIMMAGE OR COMPETITION
- PHYSICAL EXPIRATION DATE:** / /

SPORT	Fall: _____
	Winter: _____
	Spring: _____
	Paid: _____

CHECKS TO CVHS

NAME: _____ BIRTHDAY: _____ AGE: _____ SEX: _____ GRADE: _____
 ADDRESS: _____ CITY: _____ ZIP CODE: _____
 PARENT/GUARDIAN'S NAMES: _____ HOME PHONE: _____
 FATHER'S PHONE DURING DAY: _____ MOTHER'S PHONE DURING DAY: _____
 EMAIL ADDRESS: _____

IN AN EMERGENCY, IF PARENTS CANNOT BE REACHED, NOTIFY:

NAME: _____ PHONE: _____
 FAMILY PHYSICIAN: _____ PHONE: _____
 HOSPITAL (Please indicate): _____ PHONE: _____
 FAMILY DENTIST: _____ PHONE: _____

ALLERGIES: _____ MEDICATIONS: _____
 Medical conditions, including head injuries in last 5 years: _____

SCHOOL(S) ATTENDED LAST 12 MONTHS: _____

YEAR YOU ENTERED 9TH GRADE? _____ MONTH/YEAR YOU ENTERED HS? _____

HAVE YOU PREVIOUSLY ATTENDED THIS SCHOOL . . . WITHDRAWN AND LATER RETURNED? No Yes

I hereby give my consent to release pictures, name or other information pertaining to my student/athlete to use on a district website.

I hereby give my consent for medical treatment deemed necessary by physicians designated by school authorities and/or for transportation to a hospital emergency room for treatment for any illness or injury resulting from his/her athletic participation.

I understand this authorization will only be enforced when I cannot personally be contacted and provide for immediate treatment.

Signed (Parent or Guardian)

Date

