

## Interscholastic Athletic Participation Agreement

Student's Name \_\_\_\_\_

Current Grade \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_ Gender \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_

Email \_\_\_\_\_

Has my permission to participate in interscholastic competition in

\_\_\_\_\_ ( )Mod ( )Frosh ( )JV ( )Varsity  
*Sport*

At The Aquinas Institute and to accompany the team as a member on its out of town trips. I hereby certify that his/her birth date is \_\_\_\_\_ (MM/DD/YY).

I certify that the questions in the Health History Review are answered accurately.

I understand that the district DOES NOT provide any type of accident and/or medical insurance for participants in the Interscholastic Athletic Program.

I understand that the district does not assume responsibility for lost or broken corrective lenses or orthodontic devices. In the event of an emergency, my signature below constitutes my permission for my child to receive medical evaluation and necessary treatment to ensure his/her health and safety. Such treatment may come from either my child's physician or medical facility as deemed appropriate by the supervising staff member at his/her discretion. I guarantee payment for any medical treatment provided for my child under this authorization.

Insurance Co. \_\_\_\_\_

Emergency Contact \_\_\_\_\_

I have read the NYSPHSAAA Concussion Fact Sheet , the Handbook and Code of Conduct posted on the Aquinas website and I agree to abide to the policies, regulations, rules and expectations pertaining to the Interscholastic Athletic Program. I understand there are inherent risks to all sports that may include catastrophic outcomes, permanent disability or death.

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

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

High School Attended LAST YEAR \_\_\_\_\_

*Return to Athletic Office*

