Developing Servant Leaders – Restoring America's Heritage

ATHLETIC PROGRAM AUTHORIZATION

Scholar Name: _____ Birthdate: _____

Address: _____

4th/8th Period Teacher: _____ / _____ Grade: _____

Parent/Guardian Contact:

Father: _____ Email: _____

Home #: _____ Work #: _____ Cell #: _____

Lives With: ☐ Yes ☐ No JAA Authorized Driver: ☐ Yes ☐ No ☐ Interested

Mother: _____ Email: _____

Home #: _____ Work #: _____ Cell #: _____

Lives With: ☐ Yes ☐ No JAA Authorized Driver: ☐ Yes ☐ No ☐ Interested

JAA ATHLETICS INFORMED CONSENT

I understand that the John Adams Academy Staff will take all reasonable precautions to insure that the risk of injury to athletes is minimized. However, even though these precautions are taken there is still a chance of injury, and in rare instances even severe injury and death.

I have been informed of these risks, understand them, and feel that the benefits of participation outweigh the risks involved. My signature below gives my child permission to participate in a John Adams Academy Activity.

Parent/Guardian Signature: _____ Date: _____

EMERGENCY INFORMATION

Emergency Contact (Person to call if parent cannot be reached):

Name/Relationship: _____ Phone: _____

Name/Relationship: _____ Phone: _____

Name/Relationship: _____ Phone: _____

In case of an accident or other emergency, when a parent/guardian cannot be reached, I hereby authorize a representative of John Adams Academy to make arrangements, as he/she considers necessary, for my child to receive medical or hospital care, including necessary transportation. I authorize such care and treatment to be performed by any licensed physician or surgeon. John Adams Academy DOES NOT provide medical insurance benefits for students who choose to participate in activities programs.

SPORTS HEALTH INFORMATION

Scholar's Name _____ Grade _____ Today's Date_____

The information is confidential and will be accessed only by coach/athletic designee involved with your scholar.

Physician's Name:_____ Phone: _____

Dentist's Name:_____ Phone: _____

Insurance Company: _____ Policy #: _____

Does your scholar wear glasses or contacts? _____

Has your scholar had any of the following? (Please check and describe any problems.)

☐ Serious Illness _____
☐ Serious Accident _____
☐ Operations _____
☐ Hospitalizations_____
☐ Head Injury _____
☐ Ear Infections_____
☐ Allergies _____
☐ Frequent colds, minor illness _____
☐ Seizures _____
☐ Vision Problems _____
☐ Hearing Problems _____
☐ Speech Difficulties _____
☐ Learning Difficulties_____

Please check below if your scholar is subject to any condition that may result in an emergency situation, such as:

☐ Epilepsy ☐ Diabetes ☐ Fainting Spells ☐ Heart Conditions
☐ Severe Bee Sting Allergy (*prescription medication needed immediately*) ☐ Other _____

Is your scholar taking any medication on a regular basis? ☐ Yes ☐ No _____

Are there any special conditions your scholar's coach should be aware of? _____

_____

Any limitation in physical activity? _____

Currently under doctor's care for health problems? _____

Any other information the school/coach should know? _____

_____

_____

_____

Signature: _____ Relation to Scholar :_____