

#### NEW LENOX SCHOOL DISTRICT 122

102 South Cedar Road, New Lenox, Illinois 60451 Phone 815-485-2169 Fax 815-485-2236

### Appendix A

#### **Authorization for Medical Treatment**

To be submitted to the Athletic Director (please print) Student Sport/Activity Parent/Guardian Home phone Home Address Cell phone Physician Physician phone Medical information: (list allergies, medications, conditions and any know restrictions) In the event of a medical emergency and if reasonable attempts to contact me using the telephone numbers listed above are unsuccessful: I, as parent or legal guardian of the above student, do hereby authorize: 1. Treatment by a licensed medical physician of my child/ward in the event of a medical emergency that, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed, and 2. Transfer of my child/ward to any hospital reasonably accessible at my expense. Parent/Guardian signature Date



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# Appendix B

| Student  | Sport/Activity   |  |      |
|--|--|--|------|
|  |  | 8  |      |
| Parent/Guardian  | Home phone   | -  |      |
|  |  | 24   |      |
| Home Address   | Cell phone   |  |      |
|  |  |  |      |
| Emergency contact #1(relationship to student)  | Contact phone  |  |      |
| - Consider the contract of the |  | 10.00  |      |
| Emergency contact #2(relationship to student)  | Contact phone  |  |      |
| Emergency contact #2(relationship to studenty  | 33   |  |      |
|  | Dhysisian phone  |  |      |
| Married  |  |  |      |
|  | Physician phone  | 10   | 5.1  |
| [] Epilepsy [] Allergie  |  |  | 5    |
| Medical History: Date of Birth: ] Heart condition [] Diabetes [] Asthma ] Epilepsy [] Allergie   | Height: Weight:<br>a: []Requires child to self-administer<br>es: [] Requires student to carry EpiPe  |  | 5    |
| Medical History: Date of Birth:  | Height: Weight:<br>a: []Requires child to self-administer<br>es: [] Requires student to carry EpiPe  |  | 52   |
| Medical History: Date of Birth:  [] Heart condition [] Diabetes [] Asthmatical Epilepsy [] Allergies  [] Other   | Height: Weight:<br>a: []Requires child to self-administer<br>es: [] Requires student to carry EpiPe  |  | 52   |
| Medical History: Date of Birth:  ] Heart condition [] Diabetes [] Asthmatical Properties [] Allergies [] Other   | Height: Weight:<br>a: []Requires child to self-administer<br>es: [] Requires student to carry EpiPe  |  | 52   |
| Medical History: Date of Birth:  ] Heart condition [] Diabetes [] Asthma ] Epilepsy [] Allergie ] Otherist all medications (prescribed and over the conjuries (brief description and dates)  Surgeries (brief description and dates)   | Height: Weight:<br>a: []Requires child to self-administer<br>es: [] Requires student to carry EpiPe<br>ounter)   |  | 2    |
| Medical History: Date of Birth:  ] Heart condition [] Diabetes [] Asthmatical Epilepsy [] Allergies ] Other  | Height: Weight:<br>a: []Requires child to self-administer<br>es: [] Requires student to carry EpiPe<br>ounter)   |  | 0    |
| Medical History: Date of Birth:  ] Heart condition [] Diabetes [] Asthmate [] Epilepsy [] Allergies [] Other  List all medications (prescribed and over the conjuries (brief description and dates)  Surgeries (brief description and dates)  Physical activity restrictions (brief description and certify that:  1. My child is in good health and is can  | Height: Weight: a: []Requires child to self-administer es: [] Requires student to carry EpiPe counter) and duration)  pable of participating in the above sp   | en®  | - v  |
| Medical History: Date of Birth:  ] Heart condition [] Diabetes [] Asthmatical Epilepsy [] Allergies ] Other List all medications (prescribed and over the conjuries (brief description and dates)  Surgeries (brief description and dates)  Physical activity restrictions (brief description and certify that:  1. My child is in good health and is can exists to limit his/her participation.   | Height: Weight: a: []Requires child to self-administer es: [] Requires student to carry EpiPe counter)  and duration)  pable of participating in the above sp I assume full responsibility for his/her   | en®  | need |
| Medical History: Date of Birth:  ] Heart condition [] Diabetes [] Asthmatical Epilepsy [] Allergies ] Other  | Height: Weight: a: []Requires child to self-administer es: [] Requires student to carry EpiPe counter)  and duration)  pable of participating in the above sp I assume full responsibility for his/her any changes.  | en®  ort or activity. No rephysical condition                  | need |
| Medical History: Date of Birth:  [] Heart condition [] Diabetes [] Asthmate [] Epilepsy [] Allergies [] Other ist all medications (prescribed and over the conjuries (brief description and dates)  Surgeries (brief description and dates)  Physical activity restrictions (brief description and dates)  certify that:  1. My child is in good health and is can exists to limit his/her participation. participation, and will notify you of a completed and submitted the  | Height: Weight: a: []Requires child to self-administer es: [] Requires student to carry EpiPe counter)  and duration)  pable of participating in the above sp I assume full responsibility for his/her any changes.  | oort or activity. No rephysical condition to Form allowing the | need |
| Medical History: Date of Birth:  [] Heart condition [] Diabetes [] Asthmate [] Epilepsy [] Allergies [] Other  List all medications (prescribed and over the conjuries (brief description and dates)  Surgeries (brief description and dates)  Physical activity restrictions (brief description and dates)  certify that:  1. My child is in good health and is can exists to limit his/her participation. participation, and will notify you of a school to seek medical treatment for reasonable attempts to contact me   | Height: Weight: a: []Requires child to self-administer es: [] Requires student to carry EpiPer counter)  and duration)  pable of participating in the above splassume full responsibility for his/hermany changes.  a Authorization for Medical Treatment or my child in the event of a medical eare unsuccessful. | ort or activity. No rephysical condition the emergency when    | and  |
| Medical History: Date of Birth:  [] Heart condition [] Diabetes [] Asthmate [] Epilepsy [] Allergies [] Other  List all medications (prescribed and over the conjuries (brief description and dates)  Surgeries (brief description and dates)  Physical activity restrictions (brief description and dates)  certify that:  1. My child is in good health and is can exists to limit his/her participation. participation, and will notify you of a school to seek medical treatment for   | Height:  | ort or activity. No rephysical condition the emergency when    | and  |



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# Appendix C

# **Sports Contract**

| I have read and understand the rules governing participation, academic el all New Lenox School District 122 athletes:                              | gibility and Co | de of Conduct fo | or      |
|--|-----------------|------------------|---------|
| [ ] Agreement to Participate – Student   |                 |                  |         |
| [ ] Academic Eligibility Information   |                 |                  |         |
| [ ] Code of Conduct – Athlete  |                 | , e-4            |         |
| [ ] Concussion Information Sheet   |                 | -4               |         |
| Print Student Athlete's Name   |                 |                  |         |
| Signature of Student   |                 |                  |         |
| We have read and understand the following information with our student/a responsibility as a parent and support the athletic programs at New Lenox | thlete. We reco | ognize our       | er<br>Q |
| [ ] Agreement to Participate – Parent/Guardian   |                 |                  |         |
| [ ] Athletic Handbook  |                 |                  |         |
| [ ] Authorization for Medical Treatment  |                 | , *              |         |
| [ ] Emergency Contact Information  |                 |                  |         |
| [ ] Code of Conduct – Parent   |                 |                  |         |
| [ ] Concussion Information Sheet   |                 |                  |         |
| Signature of Parent/Guardian   |                 |                  |         |
| Date   |                 |                  |         |

This form must be turned in along with the Authorization for Medical Treatment, Emergency Contact Information Sheet and Physical Form to your coach.

Participation in athletics is a privilege and not a right.