BAY-WAVELAND SCHOOL DISRTICT
ATHLETIC PARTICIPATION CLEARANCE

I hereby give consent for my child, ______________________________________, to participate in all required activities pertaining to the Bay/Waveland School District's athletic program in the sports circled below.

BAND	BASEBALL	BASKETBALL	CHEERLEADING
DANCE	FOOTBALL	SOCCER	SOFTBALL
TENNIS	TRACK	VOLLEYBALL	

I hereby acknowledge that health and accident insurance coverage is required for participation in all organized athletic activities, and further certify that my child is covered under the health and accident insurance program listed below. INSURANCE INFORMATION MUST BE COMPLETED.

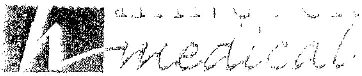
________ School Insurance   School Verification ______________________________
(Teacher Signature)

________ Other   Name of Company ______________________________

Policy Number ______________________________
(Number Required)

In addition, I assume any expenses for liability not covered by the above required insurance policy for injury received by the above named student while participating in sports authorized above and accept full responsibility for medical and hospital expenses and any other related expenses and do hereby hold harmless the Bay/Waveland School District and the Board Of Education of the Bay/Waveland School District, their agents or assigns, of responsibility for any such injury or expenses and waive any and all claims which may arise against them. I realize that participating in organized high school athletics involves the potential for injury which is inherent in all sports, sometimes severe enough to result in total disability, paralysis or death.

______________________________   ______________________________
PARENT/GUARDIAN SIGNATURE   DATE



149 Drinkwater Blvd. Bay St. Louis, MS 39521 (228) [illegible]

Pre-participation Physical Evaluation

PHYSICAL EXAMINATION

Name: ______________________ Date of Birth: ____________

Grade: ________ Height: ________ Weight: ________ Blood Pressure: ____/_____ , (____/ ____)

Vision: R 20/ ______ L 20/ ______ Corrected: Y N Pupils: Equal ______ Unequal ______

	NORMAL	ABNORMAL FINDINGS	INITIALS
MEDICAL			
Appearance			
Skin			
Marfan Stigmata			
Heart			
Pulses			
Lungs			
Abdomen			
Other:			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

CLEARANCE

☐ Cleared

☐ Cleared after completing evaluation/rehabilitation for:

____

____

☐ Not Cleared for: ______________________ Reason: ______________________

Recommendations: ____

____

Name of Physician (print/type): ______________________ Date: ____________

Address: ______________________ Phone: ____________

Signature of physician: ______________________ MD or DO

BAY HIGH SCHOOL TIGER PRIDE BAND

PARENTAL PERMISSION FOR EMERGENCY MEDICAL TREATMENT

Fill out + retur
1st day of
Band Cam
C.C.

Student's Name

Parent/Guardian's Name

Address

City State Zip

Home Phone # Work Phone # Cell Phone #

Insurance Co Name

Policy # Group #

Cardholder's Name **Cardholder's Birthday**

List any medicine allergies:

List any surgeries with approximate dates:

List any ongoing medical problems

List any medications and dosages taken on a daily basis:

List any medications and dosages taken occasionally (This includes emergency meds such as epinephrine for insect stings, headache meds, allergy/sinus meds, etc)

When was your child's last tetanus shot?

Has your child ever had?

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Diabetes
- ☐ Low Blood Sugar
- ☐ Asthma
- ☐ Allergic Reaction to insect bites/stings
- ☐ Allergic Reaction to Medication
- ☐ Fainting Spells
- ☐ Seizures
- ☐ Bleeding Problems

I authorize emergency medical treatment for above named minor.

Date