Hill View Montessori Charter Public School After School Sports Program Consent Form

Student's Name _____ M_____ F _____ Date of Birth _____ Grade _____

Parent/Guardian's Name _____ Tel (H) _____ Tel (Cell) _____

Home Address _____ Tel (W) _____
Street City

IN CASE OF AN EMERGENCY, CONTACT:

Name _____ Relationship _____ Tel (H) _____ (W) _____ (C) _____

Physician's Name _____ Telephone _____

1. Has your child had a medical illness or injury since his/her last check up or sports physical? Yes _____ No _____
Explain:

2. Does/has your child have/had a disease that affects the function of an eye, ear, testicle, kidney, or lung? Yes _____ No _____
Explain:

3. List any surgeries, fractures, sprains or dislocations:

4. Has your child ever had any of the following? Please circle "Y" for "Yes", "N" for "No"

a. Asthma	Y N	i. Allergies	Y N	**q. Head Injury**	**Y N ***
b. Fainting and/or Convulsions ns	Y N	j. Blood Disorders	Y N	r. Concussion	Y N
c. Heart Murmur/Condition	Y N	k. Arthritis	Y N	s. Seizure	Y N
d. Rheumatic Fever	Y N	l. Mononucleosis	Y N	t. Dental Problems	Y N
e. Kidney Disease/or Injury	Y N	m. Pneumonia	Y N	u. Tumors	Y N
f. Heat Stroke/Exhaustion	Y N	n. Hepatitis	Y N	v. Bridges/False Teeth	Y N
g. Diabetes	Y N	o. Bronchitis	Y N	w. Frequent Headache	Y N
h. High Blood Pressure	Y N	p. High Cholesterol	Y N		

Please explain every "Yes" answer to above questions (Date and Treatment). Also list any serious illness not previously listed. Use reverse side as needed.

5. Does your child take any prescription or nonprescription medications, pills, or use an inhaler? Yes _____ No _____
If so, please list:

6. Has your child ever taken any supplements or vitamins to help him/her gain or lose weight, or to improve performance? Yes_____ No_____

7. Does your child wear glasses? Yes _____ No _____ Contact Lenses? Yes _____ No _____ Type _____

8. Does your child use any special protective, corrective equipment or devices that aren't usually used for sports or position (for ex. Knee brace, special neck roll, foot orthotics, retainers on teeth, hearing aid)? Yes_____ No_____

9. Has your child had a Tetanus booster within the past ten years? Yes _____ Date _____ No _____

10. Do you know any reason for your child not to participate in any sports? Yes _____ No _____
If "Yes" please explain:

I understand that HVM will make every effort to contact me in the event of an emergency requiring medical attention for my child. If I am unable to be reached, I authorize HVM to contact EMS (Emergency Medical Services) and have my child transported to the nearest medical care facility and/or to this hospital:

I give me permission for my son/daughter to participate in after school activities for the 2012-2013 school year. I understand that I am responsible for his/her transportation.

_____ _____
Signature of Parent or Guardian Date

Please complete one form for each child who is participating in the program.