



Athletic Insurance and Participation Information Form

 Your son's or daughter's name and image may be used on our athletic web pages.
 Please check here if you do not want their name and image to appear on the website.

General Information

In order to participate in the Central High School athletic program, each participant must have his or her parent or guardian's permission to participate, and have in force a current accident insurance policy that will cover the participant during the entire school year.

Please type or print the following information:			School Year
Name:	<input type="text"/> Last <input type="text"/> First <input type="text"/> Middle		
Address:	<input type="text"/> Street <input type="text"/> City & State <input type="text"/> Zip		
New address? Yes <input type="checkbox"/> No <input type="checkbox"/>	Phone: <input type="text"/>		
Birth date: <input type="text"/> Month <input type="text"/> Day <input type="text"/> Year	Grade: 9: <input type="text"/> 10: <input type="text"/> 11: <input type="text"/> 12: <input type="text"/>		
Foreign Exchange Student: Yes <input type="checkbox"/> No <input type="checkbox"/>	PARENT EMAIL:		
Whom Do You Live With? <input type="text"/>	Their Address: <input type="text"/> (Other than mom or dad)		
Mother's Name: <input type="text"/>	Address: <input type="text"/>	Expires: <input type="text"/>	
Father's Name: <input type="text"/>	Address: <input type="text"/>	Sport: <input type="text"/>	
OR Court Appointed Guardian: <input type="text"/>	Address: <input type="text"/>	Sport: <input type="text"/>	
School Attended Last Year <input type="text"/>		Sport: <input type="text"/>	
STATEMENT OF INSURANCE COVERAGE FOR STUDENT ATHLETE (Please initial each statement and indicate your insurance option below)			For Office Use Only
<input type="checkbox"/> The Board of Education of Community Unit School District #4 makes available an optional insurance program which students participating in athletics are urged to purchase. This program covers accidents which occur as a result of a student's participation in school sports.			
<input type="checkbox"/> I/We assume full legal responsibility for any damages or injuries sustained by the undersigned student, not covered by insurance by us, and agree to indemnify and hold harmless the above named school district against all claims arising therefrom.			
<input type="checkbox"/> Central High School has an agreement with Carle Clinic's Outreach program that provides free evaluation. There is no agreement for actual treatment of any kind.			
Please check one: <input type="checkbox"/> I/We will obtain our own insurance	<input type="text"/>		
<input type="checkbox"/> I/We have our own family accident insurance policy	Parent / Guardian Signature		
<u>PARENT PERMIT AND SUBSTANCE ABUSE POLICY</u>			
We also agree to abide by the code of conduct as it relates to substance abuse, and understand that participation in athletics is a privilege, not a right.			
Parent/Guardian Signature: <input type="text"/>	Date: <input type="text"/>		
Student-Athlete Signature: <input type="text"/>	Date: <input type="text"/>		

Key
 0 No defect
 / Slight defect
 * Marked defect

No: _____



**ILLINOIS HIGH SCHOOL ASSOCIATION
 PHYSICIAN'S CERTIFICATE**

If student transfers, this card should be sent to the new school

Name: _____ Address: _____ Birth Date: _____

REQUIRED	Year:	20	20	20	20	20
MONTH-DAY						
HEIGHT						
WEIGHT						
GEN. POSTURE						
HEART: Murmur						
Rhythm						
Blood Pres.						
RATE: Normal						
After 15 Hops						
After 2 Min.						
HERNIA						
LUNGS: Percussion						
Auscultation						
ORTHOPEDIC: Feet						
Spine						
CONTAGION:						

RECOMMENDED	Year:	20	20	20	20	20
URINE: Spec. Grav.						
Albumin						
Sugar						
TONSILS						
NOSE AND THROAT						
GLANDS						
EARS: Right						
Left						
TEETH						
EYES: Right						
Left						
BLOOD TESTS:						
TUBERCULIN TEST:						
OTHER DEFECTS:						

In the space below, indicate athletic activities in which the student should not participate:

20 _____ : _____

20 _____ : _____

20 _____ : _____

20 _____ : _____

20 _____ : _____

EXAM BY:

1ST: _____ M.D. Date: _____

2ND: _____ M.D. Date: _____

3RD: _____ M.D. Date: _____

4TH: _____ M.D. Date: _____

5TH: _____ M.D. Date: _____

NOTE: Comment below on any defect that might be helped through corrective treatment