2019 - 2020 COUPEVILLE HGH SCHOOL
Extra-Curricular/Athletic Participant Eligibility

STUDENTS WILL BE ALLOWED TO PARTICIPATE WHEN PAPERWORK IS COMPLETED and SIGNED

STUDENT INFORMATION

STUDENT'S FIRST NAME	LAST NAME	DOB	AGE	GENDER	GRADE

FALL SPORT/ ACTIVITY	WINTER SPORT/ACTIVITY	SPRING SPORT/ACTIVITY

HOME ADDRESS/MAILING ADDRESS	HOME PHONE

PRIMARY PARENT or GUARDIAN NAME and CELL#	SECONDARY PARENT/GUARDIAN NAME and CELL#

EMERGENCY INFORMATION

Emergency Contact Name #1 (Alternate other than parent/guardian)	Contact #
Emergency Contact Name #2 (Alternate other than parent/guardian)	**Contact #**

EMERGENCY OBSERVATION and/or TREATMENT PERMSISSION or WAIVER

If the parents/guardian and/or authorized physician named above cannot be reached at the time of an emergency, and if immediate observation or treatment is urgent in the judgment of the school authorities, I authorize and direct the school authorities to send the student (properly accompanied) to the hospital or Licensed Health Care Provider most easily accessible and for such doctor to render such observation and treatment as is immediately necessary.

PHYSICIAN	PHYSICIAN PHONE
PREFERRED HOSPITAL	**HOSPITAL PHONE**

PLEASE NOTE: COACHES CARRY THIS INFORMATION AT ALL TIMES. PLEASE INCLUDE ALL HEALTH CONDITIONS INCLUDING A CONCUSSION THAT MAY BE PERTINENT TO YOUR ATHLETE.

PLEASE CHECK ALL THAT APPLY: ___severe bee sting ___reaction allergies ___reduced hearing ___asthma ___seizure disorder ___heart problems ___vision problems ___diabetes

___food allergies (please list)_____

___other (please list) _____

_____

Will medication be taken at school? YES_____ NO _____

If yes, a "Parent Authorization to Administer Medication" form must be on file in the Health Room before medication may be dispensed in the office at school)

During the last year, has your child been seriously ill? YES _____ NO _____

Had surgery, serious injury, and/or a CONCUSSION? *If yes, please note date(s) and details below **YES _____ NO _____**

_____

MEDICAL INSURANCE VERIFICATION

MUST HAVE ONE CHECKED BELOW:
STUDENTS MUST HAVE HEALTH INSURANCE INFORMATION ON FILE IN ORDER TO PARTICIPATE

☐ I have my own insurance

The insurance listed below will cover all expenses incurred should any injury occur to my child. If the medical expenses are not fully covered by insurance our family will take full responsibility of the remaining medical expenses. I give permission for my son or daughter to participate in athletics/activities representing Coupeville Middle and High School.

Insurance Cardholder's Name _____

Health Insurance Company _____

Policy # _____Group #_____

☐ I have purchased athletic insurance offered through the Coupeville School District, and give permission for my son or daughter to participate in athletics/activities representing Coupeville Middle/High School

Date Purchased_____

Please make sure all areas are accurate and complete.

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RELEASE FOR TRANSPORTATION
OF STUDENTS FROM OFF CAMPUS ATHLETICS/ACTIVITIES

ALL students will be returning to the Coupeville Middle/High School from away athletic/activity events ON the school transportation. Alternate locations to pick up your child other than the school are noted below. Please choose a location: (PLEASE NOTE: NO OTHER DROP OFF LOCATIONS ARE AUTHORIZED)

I authorize my child to be dropped off on the return to school at the:

☐ **GREENBANK STORE** (if returning via the Clinton/Mukilteo Ferry)

☐ **BIBLE BAPTIST CHURCH** (if returning via Deception Pass)

LISTED AUTHORIZED PERSONS (Must be at least 21 years of age)

A student who wishes to return to the district in a *private vehicle* must have *written permission on file* from his or her parent or guardian. Prior to being released, the Coach must be notified that the student will be leaving in a *private vehicle*, and only with those person(s) authorized on file or listed here.

My student has permission to be released ONLY to these authorized person(s) named below after an away athletic/activities events (please provide a contact number)

_____ _____ _____ _____

ACKNOWLEDGEMENT AND AGREEMENT
of the Athletic/Co-Curricular Contract

BY OUR SIGNATURES BELOW:

- **We agree that ALL the information provided on this eligibility form is accurate and complete. As any information changes we are required to update the Athletic Dept.**
- **We have read and reviewed the Coupeville Middle Sports and Co-Curricular Activities booklet in its entirety.**
- **We understand and will comply with all eligibility requirements in the booklet for the athlete and/or the co-curricular participant, including ALL listed below:**
  - **CSD Concussion and Sudden Cardiac Arrest Information**
  - **WIAA Eligibility**
  - **Co-Curricular/Athletic Code & Eligibility Acknowledgement/Agreement Contract**
  - **Physical Examination (All physicals need to cover the entire sports season)**

☞ _____ _____
Student's Signature Date

☞ _____ _____
Parent/Guardian Signature Date

CO-CURRICULAR/ATHLETIC CLEARANCE TO BE COMPETED BY THE ATHLETIC OFFICE

_____ Co-Curricular/Athletic Form Signed _____ CSD/FES/HS/RS

_____ ASB Paid / / _____ PHYSICAL (Exp.date / /)

_____ Participation Fee Paid (indicate paid sport/activity) _____ CC Fall ____ CC Winter ____ CC Spring

NOTES: