CAPE MAY COUNTY TECHNICAL HIGH SCHOOL ATHLETIC DEPARTMENT
STUDENT AND PARENT CONSENT FORM

PLEASE PRINT

Complete Legal Name: _____ _____ _____ **Circle: M or F**
(First) (MI) (Last)

Address:_____ Telephone:_____

Date of Birth____/____/____ Place of birth: _____ Grade:___ **Sport trying out for:_____**

STUDENT PARTICIPATION

This application to participate in athletics at Cape May County Technical High School is voluntary on my part and is made with the understanding that I will abide by all the eligibility rules set up by the New Jersey State Interscholastic Athletic Association and Cape Atlantic League, and receive prior to play, a physical examination. **Signature of Student Athlete**:_____ **Date: _____**

PARENT OR GUARDIAN CONSENT

I hereby give my consent for the above high school student to engage in interscholastic athletics at Cape May County Technical High School for the above sport during the current school year and to accompany the team as a member on its out-of-district trips. I understand that my son/daughter will be expected to adhere firmly to all established athletic policies, and eligibility rules, and receive prior to play, a physical examination.

Signature of Parent or Guardian:_____ Date: _____

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EMERGENCY INFORMATION AND MEDICAL TREATMENT CONSENT

(To be completed by parent)

In emergency, contact _____ Phone _____, or
_____ Phone _____.

I,_____, the parent or guardian of the above high school student recognize that as a result of interscholastic athletic participation, medical treatment on an emergency basis may be necessary, and further recognize that school personnel may be unable to contact me for my consent for emergency medical care. Therefore, I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the then existing circumstance. Please make the following notations on my son's/daughter's records:

Medication allergies: List _____Food/insect allergies: List_____

If yes, does your child require emergency medication? NO YES (Name of medication):_____

Other relevant medical information (e.g., glasses, contact lenses; prior surgeries, epilepsy; heart murmur, diabetes, seizure disorder, asthma, etc.) _____

Medication for long-term or chronic illness (ie. indicate physical or mental health condition and medications):
_____

Signature of Parent or Guardian:_____ Date _____

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Athletic Director Approval:_____ Health Office Approval:_____Restrictions: _____

- ☐ Eye protection (rec specs) due to vision problem: Eye effected: R L Both Condition: _____
- ☐ Coach: give athlete attached agreement (PINK FORM) as Athlete has: ☐Asthma ☐Life-Threatening Allergies ☐ Diabetes
- ☐ Individual Emergency Care Plan provided for: ☐ Asthma ☐ Diabetes ☐ Life-Threatening Allergy ☐ Other: _____

☐ **Note for Coach**: See school nurse for training and questions regarding athlete's medical condition.