

# MILFORD PUBLIC SCHOOLS

## ATHLETIC PERMISSION/EMERGENCY AUTHORIZATION

School \_\_\_\_\_

I hereby acknowledge I have read the Student/Athletic Handbook explaining the following:

General Policies/Procedures  
 Participation  
 Insurance Plan  
 Athletic Code of Conduct  
 Awards

Milford Extra Curricular Activities Policy  
 SCC Code of Behavior  
 CIAC Eligibility Rules  
 Athletic Equipment

I agree to adhere to these regulations while participating in athletics in the Milford Public Schools.

\_\_\_\_\_ Sport \_\_\_\_\_  
 Print Name of Student/Athlete

Signed \_\_\_\_\_ Date \_\_\_\_\_  
 Student/Athlete

I give my consent for my son/daughter to participate in the Milford Public Schools Athletic Program.

I understand that such activity involves the potential for injury which is inherent in all sports. Even with the best coaching, use of the most advanced protective equipment, and strict observance of rules, injuries are still a possibility. On rare occasions these injuries can be so severe as to result in total disability, paralysis or even death.

I understand my son/daughter will receive transportation to and from all scheduled athletic events.

I give my permission to the appropriate certified school staff or medical personnel to render emergency treatment, if required, when associated with an athletic injury or illness.

\_\_\_\_\_ has my permission to participate to participate in \_\_\_\_\_  
 Athlete's Name Sport

I/We acknowledge that I/We have read and understand this statement.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
 Parent/Guardian

Signed \_\_\_\_\_ Date \_\_\_\_\_  
 Student/Athlete

### ATHLETIC EMERGENCY INFORMATION

Student Name \_\_\_\_\_ Parent Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Grade \_\_\_\_\_ D.O.B. \_\_\_\_\_  
 Business Phones: Father \_\_\_\_\_ Mother \_\_\_\_\_

Doctor \_\_\_\_\_ Phone \_\_\_\_\_  
 Dentist \_\_\_\_\_ Phone \_\_\_\_\_  
 Highly Allergic to \_\_\_\_\_

Diabetic  Epileptic  Asthmatic  Cardiac Problems  Contacts  Other

Hospital Preference \_\_\_\_\_ Medications \_\_\_\_\_

In the event parents cannot be reached, call:  
 Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Name \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Insurance Carrier \_\_\_\_\_  
 Parent/Guardian

You have my permission to take whatever action is deemed necessary for the health and welfare of my son/daughter.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Parent/Guardian

**PLEASE COMPLETE THIS FORM AND RETURN IT TO YOUR COACH.**