Coast Union High School
Athlete Information & Participation Application

All information is required and must be completed by the parent or guardian of student. All signatures are required.

Student Athlete Information

Use Black or blue ink and print neatly.

Athletes Full Name:_____Home Phone:_____
First MI Last

Physical Address:_____
Street Address City Zip Code

Date of Birth_____ Age_____ Grade_____

Mother's Name_____Home Phone_____Work #_____Cell #_____

Father's Name_____Home Phone_____Work #_____Cell #_____

In an emergency if the parent(s) cannot be reached, notify:

Name:_____Relationship_____Home Phone_____Work #_____

Name:_____Relationship_____Home Phone_____Work #_____

MEDICAL AUTHORIZATION

As, the parent or legal guardian of the above listed athlete, I hereby consent to any hospital, emergency center, doctor, nurse, and/or paramedic, authorization to grant treatment to my child, provided that the hospital is unable to reach a parent or guardian at the above listed phone numbers. Further, should the attending physician determine, after examination, that life-saving procedures may be necessary; permission is hereby extended to the above parties to grant same. Additionally, I agree to hold harmless Coast Unified School District personnel and Coast Unified School District Board of Trustees by my action of granting said permission.

_____ _____ _____
Signature of Parent/Guardian Printed Name of Parent/Guardian Date

Insurance Coverage

Ca. Ed. Code requires insurance coverage on all students who wish to participate in interscholastic sports. **NOTE:** Your attention is directed to the fact that many insurance companies exclude Tackle Football Coverage. **Please read your policy, you may need additional coverage.**

Insurance Company/Provider_____Policy #_____

___**Yes,** I want to purchase the SISC Student Accident Coverage. ___**No**, I do not want to purchase the SISC Student accident Coverage.

Athlete Medical Information

List all known medical conditions, allergies, and/or medication that your student is currently taking.

Drug Allergies:_____Prescirbed Medication:_____

Medical Conditions;_____
(i.e. Asthma, Diabetes, Allergic reactions, etc.)

Previous Injuries, surgeries, fractures, etc._____

Medical Evaluation

(To be completed by physician)

Height_____ Weight_____ Pulse_____ Blood Pressure_____Heart_____Lungs_____

Muscular Skeletal: Back, Neck, Joints:_____

Based on this limited, pre-participation evaluation, this student; ____is able to engage in sports
____is not cleared and should see additional medical evaluation

Comments:_____

Date of Examination_____ Signature of Physician_____

Physician Name Printed_____