SCHOOL DISTRICT OF CAMERON

EXTRA-CURRICULAR REGISTRATION, PERMISSION, WAIVER, AND CODE AGREEMENT FORM

Student Name ________________________ Grade ______ School Year ______-______

To minimize the process of requesting signatures on the different forms required for your son/daughter named above to participate in various school activities and programs, the Athletic Department has developed this form to help simplify the process. Please complete all sections on the ***front and back*** *of this form. This form will need to be completed prior to your son/daughter participating in any extra-curricular activity, practice, or contest sponsored by the Cameron School District.*

Co-Curricular Code of Conduct (Please sign each year)

My signature below indicates that I have read this statement (Code can be found on the athletics section of the website. http://www.cameron.k12.wi.us/athletics.html), understood it completely, and agree to be bound by its terms. I also understand that the extra-curricular code of conduct is in effect twelve months a year.

Student Signature ___________________________________ *Date* ____________________

Parent Signature ____________________________________ *Date* ____________________

Wisconsin Interscholastic Athletic Association Eligibility Form (WIAA requires a signature each year)

I have read and understand the WIAA Eligibility Rules (http://www.wiaawi.org/Schools/EligibilityRulesForms.aspx) I agree to abide by all WIAA rules and regulations as they apply to athletic participation while I am a student in the Cameron School District. I also understand that the WIAA rules are in effect twelve months a year.

Student Signature ___________________________________ *Date* ____________________

Parent Signature ____________________________________ *Date* ____________________

Media Release Form (Please sign each year)

I give permission for my son/daughter named above to be interviewed, mentioned, photographed, videotaped and quoted by the news media and employees of the Cameron School District before, during and after participation in a extra-curricular activity sponsored by the Cameron School District.

Parent Signature ____________________________________ *Date* ____________________

Medical Treatment Consent (Please sign each year)

The parent or guardian of a Cameron School District athlete recognizes that as a result of athletic participation, medical treatment on an emergency basis may be necessary. The athlete's parent further recognizes that school personnel may be unable to contact them for their consent for emergency medical care. The Cameron School District does hereby secure parental/guardian consent in advance to such emergency care, including hospital care, as may be deemed necessary under the then existing circumstance.

Parent Signature ______________________________________ *Date* _____________

MORE SIGNATURES NEEDED ON THE BACK OF THIS FORM

Concussion Awareness Form (Please sign each year)

As a Parent and as an Athlete it is important to recognize the signs, symptoms, and behaviors of concussions. By signing this form you are stating that you understand the importance of recognizing and responding to the signs, symptoms, and behaviors of a concussion or head injury.

Parent Agreement:

I ________________________________ have **read** the Parent Concussion and Head Injury Information and **understand** what a concussion is and how it may be caused. I also understand the common signs, symptoms, and behaviors. I agree that my child must be removed from practice/play if a concussion is suspected.
I understand that it is my responsibility to seek medical treatment if a suspected concussion is reported to me.
I understand that my child cannot return to practice/play until providing written clearance from an appropriate health care provider to his/her coach. I understand the possible consequences of my child returning to practice/play too soon.

Parent/Guardian Signature____Date_________________

Athlete Agreement:

I_______________________________ have **read** the Athlete Concussion and Head Injury Information and **understand** what a concussion is and how it may be caused. I understand the importance of reporting a suspected concussion to my coaches and my parents/guardian. I understand that I must be removed from practice/play if a concussion is suspected. I understand that I must provide written clearance from an appropriate health care provider to my coach before returning to practice/play. I understand the possible consequence of returning to practice/play too soon and that my brain needs time to heal.

Athlete Signature____Date__________________

Wisconsin Interscholastic Association Alternate Year Athletic Permit Card
(This must be signed every-other-year and an updated physical must be done on alternate years.

Physical Date _____________ School Year _________________

Name____ Grade ________ Date of Birth__________

Present Address____Phone_________________

Parent's Place of Employment____

Family Physician ___________________________________Family Dentist______________________

Name of Private Insurance Carrier ___________________________Telephone____________________

Subscriber Member Name (Primary Insured) ____

1. I hereby give my permission for the above student to practice and compete and represent the school in WIAA approved sports.
2. I also attest to the fact that the above named student has had no injury or illness serious enough to warrant a medical evaluation prior to participating this school year.
3. Pursuant to the requirements of the Heath Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder (collectivity known as "HIPAA"), I authorize health care providers of the student named above, including emergency medical personnel and other similarly trained professionals that may be attending an interscholastic event or practice, to disclose/exchange essential medical information regarding the injury and treatment of this student to appropriate school district personnel such as but not limited to: Principal, Athletic Director, Athletic Trainer, Team Physician, Team Coach, Administrative Assistant to the Athletic Director and/or other professional health providers, for purposes of treatment, emergency care and injury record-keeping.
4. It is recommended that information regarding your child's allergies and prescribed medication be made available.

Parent: If there is any question that this student may not be qualified for athletic competition without,at least, a partial re-evaluation, contact your medical advisor before signing card.

Signature of Parent____Date___________________
ALL STUDENTS PARTICIPATING IN INTERSCHOLASTIC ATHLETICS MUST HAVE THIS ALTERNATIVE CARD ON FILE AT THEIR SCHOOL PRIOR TO PRACTICE OR PARTICIPATION.

FOR OFFICE USE ONLY

Physical Date _____________ Alternate Year Card ___________

Fee Receipt # _______________ Date ____________