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

Please Print: Sport trying out for (this season only): ___________________ Circle one: Boys or Girls Team

Athlete's Legal Name: _______________________ _____ ___________________________
(First) (MI) (Last)

Nickname or Preferred Name: _______________________ Date of Birth____/____/____ Grade: ____

This application to participate in athletics is voluntary on part of the athlete. The athlete will abide by all the eligibility rules set up by the New Jersey State Interscholastic Athletic Association and Cape Atlantic League. The athlete will receive, prior to play, a physical examination on approved NJSIAA forms.

Student Athlete Signature:_______________________ **Signature of parent/guardian:**________________

Complete Address: ____

Emergency, contacts: #1______________________________ Phone(s) ___________________________

#2______________________________ Phone(s) ___________________________

I,________________________, the guardian/parent of the above listed athlete, consent that he/she engage in interscholastic athletics and accompany the team on its out-of-district trips. I understand that, as a result of interscholastic athletic participation, medical treatment on an emergency basis may be necessary. I recognize that school personnel may be unable to contact me for my consent to emergency medical care. I consent, in advance, to emergency care, including hospital care, as deemed necessary.
Make the following notations on my child's record:

List ALL Allergies: Medications:_____________________ Food:_________________ Insect: ____________

If yes, to Food or Insect allergy, does your child require emergency Epinephrine (i.e. EpiPen)? **YES** **NO**

Relevant medical information (e.g. hearing or vision problems, eyeglasses, contact lenses; prior surgeries, epilepsy, heart condition, diabetes, seizure disorder, asthma, etc.): _______________________________
____

Medication for long-term or chronic illness (indicate conditions and medications):
____

Signature of Parent or Guardian:___________________________________ **Date** ________________

*********************************** **FOR OFFICE USE ONLY** ***********************************
Restrictions or other health recommendations: ____
Significant past injuries (concussion, etc.): ____
☐ Eye protection (rec specs) due to vision problem: Eye effected: R L Both Condition: _____________________
☐ Coach: give athlete attached agreement (PINK FORM): ☐Asthma ☐Life-Threatening Allergies ☐ Diabetes
☐ Individual Emergency Care Plan for: ☐ Asthma ☐ Diabetes ☐ Life-Threatening Allergy ☐ Other: ______________
☐ **Note for Coach**: See school nurse for training and questions regarding athlete's medical condition.

Health Office Approval: _____/____/_____ **Nurse's Initials:** ____ **Athletic Director Approval:** _____/_____/_____