



SPANISH SPRINGS HIGH SCHOOL

ATHLETICS DEPARTMENT

ATHLETIC ELIGIBILITY CLEARANCE

“QUICK FORM”

OFFICE USE

Fee Paid: _____

GPA: _____

Cleared: _____

Student: _____ M/F _____ Date of Birth: _____ Grade: _____

I have cleared this year () for: SPORT _____

Now, I would like to try out for: SPORT _____

STUDENT EMERGENCY INFORMATION

Parent/Guardian’s Name: _____ Relationship: _____

Address: _____

Phone: (H) _____ (W) _____ (C) _____

Parent/Guardian’s Name: _____ Relationship: _____

Address: _____

Phone: (H) _____ (W) _____ (C) _____

One person you recommend we call in the event you cannot be reached:

Name: _____ Relationship: _____

Phone: (H) _____ (W) _____ (C) _____

Preference of Physicians: (Please include name, telephone number and address.)

Preference of Hospital: _____

Medical history, physical limitations or problems that should be known by the coach:

HEALTH/ACCIDENT INSURANCE: I understand my child/ward must be covered by health/accident insurance to participate in this athletic activity and it is solely my responsibility to ensure my child/ward is covered by health/accident insurance. By signing this form, I attest that my child/ward is covered by health/accident insurance.

As parent/guardian, I authorize and direct WCSD to obtain medical care for my child/ward in the event such care is necessary. I understand that if possible, I will be contacted in the event my child/ward requires medical attention. I grant to a licensed health care provider or accredited hospital permission to perform any necessary medical and/or surgical procedures that are essential for the treatment of my child/ward and agree to be responsible for payment for such care. I release WCSD, its Board of Trustees, employees, volunteers and agents from any costs, damages, liability or loss resulting from the exercise of discretion in securing medical care for my child/ward.

Student Signature: _____

Date: _____

Parent/Guardian Signature: _____

Date: _____