



_____ SCHOOL YEAR
SPORTS PERMISSION FORM

STUDENT'S NAME: _____

GRADE: _____

STUDENT'S NAME: _____

GRADE: _____

Students above have permission to participate in the activities at Valley Christian Academy (VCA).

- ✓ I agree to read the Athletic Handbook and following terms and any additional terms established by VCA.
- ✓ I understand sports are competitive and injuries may occur. I acknowledge **I am responsible** for the **Parent/Athlete Concussion Information** located on the Intramural page and will **turn in a copy** along with this Permission Form. I agree not to pursue legal action against VCA, or any of the coaches should my son/daughter become injured as a result of participation. **(If my son/daughter participates in intramurals, this form will act as the emergency medical and permission form.)**
- ✓ I am aware that my son/daughter may be photographed and/or name published in the media. (Media includes newspaper, newsletters, programs, brochures, VCA's website or any other type of format by any organization.)
- ✓ I agree to pay the amount designated on the website for each sport. I have also read the documents on the Middle School Athletics web page and are in agreement and willing to support the athletic program.
- ✓ I understand my son/daughter may ride in an insured volunteer's vehicle. Unless arrangements are made, I am responsible to provide transportation to and from the sporting event.

PARENT OR GUARDIAN NAME:

PHONE NUMBER:

(____) _____ - _____
(____) _____ - _____

ADDRESS: _____

I hereby **give consent** for the following medical care providers to be called if parents cannot be reached:

DOCTOR:	PHONE:
DENTIST:	PHONE:

In the event that reasonable attempts to reach the Emergency Contacts listed above have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the above named doctor or dentist, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist and (2) the transfer of the student to the above named hospital or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before the surgery is performed.

Facts concerning the student's medical history: including allergies, medications being taken, and any physical impairment to which a physician should be alerted:

STUDENT'S NAME: _____ LAST TETANUS SHOT: ____/____/____

STUDENT'S NAME: _____ LAST TETANUS SHOT: ____/____/____

PARENT OR GUARDIAN SIGNATURE:

DATE:

____/____/____