

**Bangor Middle School Athletics (JFDS / WSCS)
PARENT CONSENT FORM**

Student's Name: _____ Sex: _____

Age: _____ Date of Birth: _____ Grade: _____

Athletic restrictions known by parent: _____

Any medical conditions or allergy we should be aware of: _____

Is student currently under doctor's care or taking any medications? _____

NOTIFY IN CASE OF EMERGENCY: _____

Parent/Guardian name: _____

Home Phone: _____ Work Phone: _____

Address: _____

Family Doctor: _____ Doctor's Phone: _____

INSURANCE: All students who participate in interscholastic athletic programs must have some form of insurance to cover injuries. **This section MUST be filled in:**

Insurance Company: _____

Policy # (or S.S.# of policy holder): _____

PARENTAL CONSENT: I hereby certify that the student named above may take part in interscholastic athletics for the school year _____ which involves practice sessions, participation in athletic events and transportation to and from such events. I have read the Candidate's Agreement Statement below and agree to its terms.

Parent/Guardian Signature

Date

CANDIDATE'S AGREEMENT STATEMENT

I, _____, if selected as a member of any group representing James F. Doughty School or William S. Cohen School, do hereby agree to abide by all requirements of the activity and school policies and transportation rules set forth by the school and coaching/advisor staff. It is understood that these regulations are to be in effect for as long as I am a member of the activity on the playing fields, courts or during performances, at school or outside of school. It is understood that if I violate the rules and policies set forth by the school, it may lead to immediate dismissal from the activity.

Student Signature

Date

PARENT FORM – JFDS / WSCS
HEALTH HISTORY UPDATE AND PARENT CONSENT
(TO BE FILLED OUT BY PARENT/GUARDIAN)

Student's Name: _____ Grade: _____

Age: _____ Date of Birth: _____ Sex: _____

Home Address _____ Home Phone: _____

EMERGENCY CONTACT: _____ Phone: _____

Has/Is your child: (Please circle yes or no)

- | | |
|--|--------|
| 1. Ever had an illness last more than a week? | Yes No |
| 2. Under a physician's care now? | Yes/No |
| 3. Taking any medications? | Yes/No |
| 4. Ever had injuries requiring medical attention? | Yes/No |
| 5. Ever had a surgical operation? | Yes/No |
| 6. Ever stayed overnight in a hospital? | Yes/No |
| 7. Allergic to any medication, foods, insect bites, or other Substances? | Yes/No |

Please explain any "Yes" answers:

Does your child wear contact lenses? Yes/No

Has your child seen a dentist in the past 6 months? Yes/No

Most recent Tetanus Toxoid immunization: Date _____

Was this a booster? Yes/No

Has your child or anyone in the immediate family had: (Please check if yes)

_____ Asthma _____ Convulsions or Epilepsy

_____ Diabetes _____ Migraine Headaches

_____ High Blood Pressure _____ Kidney or Bladder trouble

_____ Heart Murmur _____ Hernia

_____ Rheumatic Fever _____ Tendency to bruise/Bleed easily

Please explain any checks for above conditions:

Parent/Guardian Signature _____ Date _____