



Athletics Parent/Student Agreement and Permission Form

2018-2019 School Year

Student Agreement

I, _____, acknowledge that I have read and understood the ACA Athletic Manual and am willing to adhere to the philosophy and expectations stated within it as I participate in ACA Athletics during the 2018-2019 school year.

Student Athlete's signature _____ Date: _____

Parent Agreement

I, _____, acknowledge that I have read and understood the ACA Athletic Manual and am willing to allow my child to participate in ACA Athletics during the 2018-2019 school year. I understand that my child will be held to the standards and guidelines stated within it.

Parent/Legal guardian's signature _____ Date: _____

Medical Permission for (Student's Name): _____

By its nature, participation in interscholastic athletics includes risk of injury which may range in severity from minor to disabling to even death. Although serious injuries are not common in supervised school athletic programs, it is impossible to eliminate the risk. Participants have the responsibility to help reduce the chance of injury. Participants must obey all safety rules, report all physical problems to their coaches, follow a proper conditioning program, and inspect their own equipment daily.

"I give permission for the above-named student to participate fully in all activities and travel related to participation in Arrowhead Christian Academy athletics. I further agree not to hold Arrowhead Christian Academy or anyone acting in its behalf responsible for any injury occurring to the above-named student in the proper course of such athletic activities or travel."

By signing this Permission Form, we acknowledge that we have read the above information. PARENTS OR STUDENTS WHO DO NOT WISH TO ACCEPT THE RISKS DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS PERMISSION FORM.

Student Athlete's signature _____ Date: _____

Parent/Legal guardian's signature _____ Date: _____

Please complete the medical and insurance information on the other side of this form.



Emergency Medical Authorization

This form must be made available by the coach at all team practices and games for each team member to ensure proper medical treatment by physicians or hospital in the event of serious injury.

Athlete's Name: _____

Birth Date _____ Grade _____ Sex _____

Parents' Name _____

Home Phone _____ Business Phone _____

Cell Phone _____

Address _____ Zip _____

In the event the parents cannot be contacted, please contact:
_____ at phone # _____

List sports the above-named athlete plays:

1. _____

2. _____

Drug allergies or other allergic reactions: _____

I hereby give my consent for medical treatment deemed necessary by physicians designated by school authorities and/or for transportation to a hospital emergency room for treatment for any illness or injury resulting from his/her athletic participation.

Preferred physician _____

Preferred hospital _____

I understand this authorization will only be enforced when I cannot personally be contacted and provide for immediate treatment.

Parent/Legal guardian's signature _____ Date: _____

Insurance Information

Name of Insurer _____

Policy and/or group number _____