

Student Agreement Regarding Conditions for Participation:

This application to represent my school in interscholastic athletics is entirely voluntary on my part and is made with the understanding that I have studied and understand the eligibility standards that I must meet to represent my school and that I have not violated any of them. I also understand that if I do not meet the citizenship standards set by the school or if I am ejected from an interscholastic contest because of an unsportsmanlike act, it could result in me not being allowed to participate in the next contest or suspension from the team either temporarily or permanently.

I have completed and/or verified that part of this certificate which requires me to list all previous injuries or additional conditions that are known to me which may affect my performance in so representing my school, and I verify that it is correct and complete.

Student's signature _____ Date _____

Parent Permission and Authorization for Treatment and Release of Medical Information:

We hereby give our consent for the above student to represent his/her school in interscholastic athletics. We also give our consent for him/her to accompany the team on trips and will not hold the school responsible in case of accident or injury whether it be enroute to or from another school or during practice or an interscholastic contest, and we hereby agree to hold the school district of which this school is a part, its employees, agents, representatives, coaches, or volunteers harmless from any and all liability, actions, causes of action, debts, claims, or demands of every kind and nature whatsoever which may arise by or in connection with participation by my childward in any activities related to the interscholastic program of his/her school.

If we cannot be reached and in the event of an emergency, we also give our consent for the school to obtain through a physician or hospital of its choice, such medical care as is reasonably necessary for the welfare of the student, if he/she is injured in the course of school athletic activities. We authorize the release of necessary medical information to the physician, athletic trainer, and/or school personnel related to such treatment/care. We understand that the school may not provide transportation to all events, and permit / do not permit (CIRCLE ONE) my child to drive his/her vehicle in such a case.

We further state that we have completed that part of this certificate which requires us to list all previous injuries or additional conditions that are known to us which may affect this athlete's performance or treatment and we certify that it is correct and complete.

We confirm that this application for the above student to represent his/her school in interscholastic athletics is made with the understanding that we have studied and understand the eligibility standards that our son/daughter must meet to represent his/her school and that he/she has not violated any of them. We also understand that if our son/daughter do s not meet the citizenship standards set by the school or if he/she is ejected from an interscholastic contest because of an unsportsmanlike act, it could result in him/her not being allowed to participate in the next contest or suspension from the team either temporarily or permanently. The MSHSAA By-Laws provide that a student shall not be permitted to practice or compete for a school until it has verification that he/she has basic health/accident insurance coverage, which includes athletics. Our son/daughter is covered by basic health/accident insurance for the current school

year with _____ (Name of Insurance Company)

(Policy Number) _____ Date _____

Parents or Guardian's signature _____
(All parents or guardians must sign) _____ Date _____



To be completed by athlete or parent:

Date: _____

Name: _____
Last First Middle

Address: _____
Street

City/State Zip Phone: () _____

Birthdate: _____ Age: _____ Sex: _____

Emergency Contact Person: _____

Phone: () _____ Cell Phone: () _____

Family Physician: _____

City/State: _____ Phone: () _____

Family Dentist: _____

City/State: _____ Phone: () _____

Hospital Preference: _____

