

**DSBN EXTRA-CURRICULAR ATHLETIC PROGRAM  
PERMISSION TO PARTICIPATE FORM**

*This form is to be completed on behalf of an athlete who wishes to participate in extra-curricular athletic programs and must be returned to the coach/staff member after being selected by the coach/staff to participate in the athletic activity (after tryouts).*

***It is the responsibility of the in-school coach/advisor to keep an outside coach informed of the information on this form.***

School: \_\_\_\_\_  
Student's Name: \_\_\_\_\_  
Athletic Activity: \_\_\_\_\_

**A DSBN Extra-Curricular Athletic Program Permission to Participate Form must be completed for every athletic activity.**

**TO THE PARENT/GUARDIAN**

Your child/ward has been chosen to participate in our DSBN Extra-Curricular Athletic Program. This may involve vigorous physical activity.

In case of an injury, most basic Medical Plans do not provide coverage of permanent teeth or private nurses. If you wish this coverage, it is recommended that you investigate a Student Accident Insurance Plan.

**GENERAL INFORMATION**

Home Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Home Telephone No.: \_\_\_\_\_  
Parent/Guardian: \_\_\_\_\_ Work Telephone No.: \_\_\_\_\_  
Cell Telephone No.: \_\_\_\_\_  
Parent/Guardian: \_\_\_\_\_ Work Telephone No.: \_\_\_\_\_  
Cell Telephone No.: \_\_\_\_\_  
Student's Physician: \_\_\_\_\_ Telephone No.: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Telephone No.: \_\_\_\_\_

ADMINISTRATIVE PROCEDURE

**MEDICAL INFORMATION**

1. Date of last complete medical examination *{An annual medical examination is recommended}*: \_\_\_\_\_
2. Date of last tetanus immunization: \_\_\_\_\_
3. Is your child/ward allergic to any drugs, food/medication/other?  Yes  No  
If yes, provide details: \_\_\_\_\_  
\_\_\_\_\_
4. Does your child/ward take any prescription drugs?  Yes  No  
If yes, provide details: \_\_\_\_\_  
\_\_\_\_\_
5. What medication(s) should the participant have available during the sport activity?  
Provide details: \_\_\_\_\_  
\_\_\_\_\_
6. Who should administer the medication? \_\_\_\_\_
7. Does your child/ward wear:  a medical alert bracelet  a medical alert neck chain  carry a medical alert card?  
If yes, specify what is written on it: \_\_\_\_\_
8. Does your child/ward wear any special equipment such as eyeglasses, contact lenses, and/or required to wear a brace, orthotics, etc. during athletic activities?  
 Yes  No  
If yes, provide details: \_\_\_\_\_  
\_\_\_\_\_
10. Has your child/ward been identified as being anaphylactic?  Yes  No  
If yes, does he/she carry an EpiPen?  Yes  No  
Have you completed the Emergency Action Plan for Students with Anaphylaxis (Appendix C)?  Yes  No

MEDICAL INFORMATION (cont'd)

10. Please indicate whether your child/ward has been subject to any of the following and provide pertinent details:

- Epilepsy: \_\_\_\_\_
- Diabetes: \_\_\_\_\_
- Orthopaedic problems: \_\_\_\_\_
- Deaf/Hard of Hearing: \_\_\_\_\_
- Wheezing/Asthma: \_\_\_\_\_
- Allergies: \_\_\_\_\_
- Back or spinal cord conditions or injuries (in the past two years): \_\_\_\_\_
- Head conditions or injuries (in the past two years): \_\_\_\_\_
- Swollen or hyper-mobile or painful joints, trick or lock knee: \_\_\_\_\_
- Arthritis or Rheumatism: \_\_\_\_\_
- Chronic Nosebleeds: \_\_\_\_\_
- Skin/Kidney/Intestinal Problems: \_\_\_\_\_
- Hepatitis/Mononucleosis: \_\_\_\_\_
- Severe Allergic Reaction: \_\_\_\_\_
- Serious Illness/Injury: \_\_\_\_\_
- Previous Surgery (include date): \_\_\_\_\_
- Headaches/Concussions: \_\_\_\_\_
- Dizziness/Seizures/Fainting: \_\_\_\_\_
- Vision Impairment: \_\_\_\_\_
- Joint Conditions/Injuries: \_\_\_\_\_
- Heart Conditions/Injuries (give details): \_\_\_\_\_

Concussion (give details). Please note, if a concussion has been diagnosed throughout the year, the *Concussion Final Medical Examination Documentation Request Form* (Appendix D) must be completed by the parent/guardian before the student returns to class, curricular (physical education) or extra-curricular athletic programs.

\_\_\_\_\_  
\_\_\_\_\_

11. Please indicate any other medical condition that will limit participation:

\_\_\_\_\_

ADMINISTRATIVE PROCEDURE

**Medical Services Authorization (optional)**

In a situation when emergency medical or hospital services are required by the above listed participant, and with the understanding that every reasonable effort will be made by the school/hospital to contact me, my signature on this form authorizes medical and/or hospital to administer medical and/or surgical services, including an aesthesia and drugs. I understand that any cost will be my responsibility.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**Athlete Accident Insurance Notice**

The District School Board of Niagara does not provide any accidental death, disability, dismemberment/medical/dental insurance on behalf of the students participating in the activity. For coverage of injuries, you are encouraged to consider the Student Accident Insurance Plan made available by the school to parents at the beginning of, and throughout, the school year.

**Transportation Insurance Notice**

Please review your current vehicle insurance policy for insurance coverage.

**Elements of Risk Notice (please refer to <http://Safety.OPHEA.net> for further information)**

**ELEMENTS OF RISK NOTICE** The risk of injury exists in every athletic activity. However, due to the very nature of some activities, the risk of injury may increase. Injuries may range from minor sprains and strains to more serious injuries. These injuries result from the nature of the activity and can occur without fault on either the part of the student, the school board or its employees/agents or the facility where the activity is taking place. Some activities that are identified as having the potential for more serious consequences are: alpine skiing, snowboarding, snowsports, football, broomball (ice), cheerleading (acrobatic), field hockey, field lacrosse, gymnastics, ice hockey, ringette (ice), swimming, wrestling, and/or field events: high jump, shot put. The safety and well-being of students is a prime concern and attempts are made to manage, as effectively as possible, the foreseeable risks inherent in physical activity.

PARENT/GUARDIAN SIGNATURE	Acknowledgement of Risks/Request to Participate/ Informed Consent Agreement
	I/We have read and understand the notice of Athlete Accident Insurance. ____ (initials of parent/guardian)
	I/We have read and understand the notice of Elements of Risk. ____ (initials of parent/guardian)
	I/We hereby acknowledge and accept the risk inherent in the requested activity, and assume responsibility for my/our child/ward for personal health, medical, dental and accident insurance coverage.
	Parent/Guardian Name (please print): _____
	Parent/Guardian Signature: _____ Date: _____

*Please note: The information provided on this form is collected pursuant to the District School Board of Niagara's (DSBN) responsibilities as set out in the Education Act and its regulations and in accordance with the Municipal Freedom of Information and Protection of Privacy Act (MFIPPA), and will be used only for the purposes of risk management for participation in athletic activities. Any questions with respect to the collection, use or disclosure of this information should be directed to the DSBN, 191 Carlton Street, St. Catharines, ON L2R 7P4, 905-641-2929 or your School Administrator(s)."*