HARRISON SCHOOL DISTRICT ATHLETIC DEPARTMENT
STUDENT AND PARENT CONSENT FORM

PLEASE PRINT

COMPLETE LEGAL NAME:_____ _____ _____
(First) (Middle) (Last)

Address:_____ Telephone:_____

Date of Birth___/_____/___ Place of Birth:_____ Grade:_____ Sport trying out for:_____

STUDENT PARTICIPATION

This application to participate in athletics in the Harrison School District is voluntary on my part and is made with the understanding that I will abide by all the eligibility rules set up by the New Jersey State Interscholastic Athletic Association and Harrison School District, and receive prior to play a physical examination.

Signature of Student: _____ Date: _____

PARENT OR GUARDIAN CONSENT

I hereby give my consent for the above student to engage in interscholastic athletics in the Harrison School District for the above sport during the current school year and to accompany the team as a member on its out-of-district trips. I understand that my son/daughter will be expected to adhere firmly to all established athletic policies, and eligibility rules, and receive prior to play, a physical examination.

Signature of Parent or Guardian: _____Date:_____

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EMERGENCY INFORMATION AND MEDICAL TREATMENT CONSENT
(To be completed by parent)

In emergency, contact _____ Phone_____, or
_____ Phone _____

I, _____, the parent or guardians of the above student recognize that as a result of interscholastic athletic participation, medical treatment on an emergency basis may be necessary, and further recognize that school personnel may be unable to contact me for consent for emergency medical care. Therefore, I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the then existing circumstance. Please make the following notations on my son's/daughter's records.

Medication allergies: List_____Food/insect allergies: List_____ If yes, does your child require emergency medication? NO YES (Name of Medication): _____

Other relevant medical information (e.g., glasses, contact lenses; prior surgeries, epilepsy; heart murmur, diabetes, seizure disorder, ect.) _____

Medication for long-term or chronic illness (indicate physical or mental health condition and medications

I give the school Nurse Permission to share pertinent medical information with necessary school/athletic staff.

Signature of Parent or Guardian: _____ Date: _____

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For Office Staff Only

Health Office Approval: _____ Athletic Trainer Approval: _____ Restrictions:_____

New Jersey Department of Education
Health History Update Questionnaire

Name of School: _____

To participate on a school-sponsored interscholastic or intramural athletic team or squad, each student whose physical examination was completed more than 90 days prior to the first day of official practice shall provide a health history update questionnaire completed and signed by the student's parent or guardian.

Student: _____ Age: _____ Grade: _____

Date of Last Physical Examination: _____ Sport: _____

Since the last pre-participation physical examination, has your son/daughter:

1. Been medically advised not to participate in a sport? Yes ☐ No ☐
   If yes, describe in detail:
2. Sustained a concussion, been unconscious or lost memory from a blow to the head? Yes ☐ No ☐
   If yes, explain in detail:
3. Broken a bone or sprained/strained/dislocated any muscle or joints? Yes ☐ No ☐
   If yes, describe in detail.
4. Fainted or "blacked out?" Yes ☐ No ☐
   If yes, was this during or immediately after exercise?
5. Experienced chest pains, shortness of breath or "racing heart?" Yes ☐ No ☐
   If yes, explain
6. Has there been a recent history of fatigue and unusual tiredness? Yes ☐ No ☐
7. Been hospitalized or had to go to the emergency room? Yes ☐ No ☐
   If yes, explain in detail
8. Since the last physical examination, has there been a sudden death in the family or has any member of the family under age 50 had a heart attack or "heart trouble?" Yes ☐ No ☐
9. Started or stopped taking any over-the-counter or prescribed medications? Yes ☐ No ☐
10. Been diagnosed with Coronavirus (COVID-19)? Yes ☐ No ☐

    If diagnosed with Coronavirus (COVID-19), was your son/daughter symptomatic? Yes ☐ No ☐

    If diagnosed with Coronavirus (COVID-19), was your son/daughter hospitalized? Yes ☐ No ☐
11. Has any member of the student-athlete's household been diagnosed with Coronavirus (COVID-19)? Yes ☐ No ☐

Date: _____ Signature of parent/guardian: _____

Please Return Completed Form to the School Nurse's Office