DENVER PUBLIC SCHOOLS
ATHLETIC PARTICIPATION/
PARENTAL PERMISSION FORM

***WARNING:** Although participation in supervised interscholastic athletics and activities may be one of the least hazardous in which any student will engage in or out of school, **BY ITS NATURE, PARTICIPATION IN INTERSCHOLASTIC ATHLETICS INCLUDES A RISK OF INJURY WHICH MAY RANGE IN SEVERITY FROM MINOR TO LONG-TERM CATASTROPHIC INJURY and perhaps FATAL ACCIDENTS.** Although serious injuries are not common in supervised school athletic programs, it is impossible to eliminate this risk. I have read and understand the CHSAA Eligibility Rules as documented here as well as specifically read in the CHSAA Bylaws. I understand and acknowledge the inherent risks of participating in Athletics and by signing this acknowledgement, I affirm my responsibility to prevent and report hazing. I also understand that any violation of this could result in school or team consequences that could include dismissal from the activity or further disciplinary consequences and/or referral to law enforcement.

PLEASE INITIAL EACH ITEM AND SIGN BELOW:

____*School district transportation will be utilized by all teams as available. When school district transportation is not available, transportation will be as authorized by the school Athletic Director and coach.

____*I have read the attached information regarding conduct and academic eligibility with my son/daughter, and understand that athletes must abide by its terms.

____*I have read and understand the guidelines for athletic participation as outlined in the CHSAA Competitor's Brochure and the Athletic Handbook. As a student-participant, I will not be the organizer of, or participant in an activity constituting hazing as defined and outlined by the CHSAA bylaws.

____*Students in the Denver Public Schools are eligible to participate in a medical, dental, and life insurance program at their own expense if private insurance is unavailable. The building principal or athletic director has the necessary forms.

____*Players must obey all safety rules, report all physical problems to their coaches, follow a proper conditioning program, and inspect their own equipment daily.

____*By signing this Permission Form, I acknowledge that I have read and understood the above warning and conditions. Parents or students who do not wish to accept the risks described in this warning should not sign this permission form.

____*By signing this form, I consent to emergency medical treatment, hospitalization or other medical treatment by a physician, qualified nurse, certified athletic trainer, and/or hospital, in the event of injury or illness. I hereby waive any liability of Denver Public Schools, its agents or employees arising out of such medical treatment.

____*By signing this form I give permission to sports medicine staff to provide over the counter medication to my student-athlete per the medication's dosage instructions. I have included any allergy information in my child's physical. I will inform the athletic department directly if I choose not to allow this option.

I hereby give my consent for _____ to compete in athletics for
(PRINT Student name)
DPS in Colorado High School Activities Association approved sports with the above listed disclosures.

Parent/Guardian Signature_____ Date_____

Student Signature_____ Date_____

Note: No student shall represent their school in interschool athletics until there is on file with the school principal or athletic director a signed physical certifying that he/she has passed an adequate physical examination within the past year, that in the opinion of the examining physician, physician's assistant, or nurse practitioner, he/she is physically fit to participate in high school athletics; and documentation stating that he/she has the consent of his/her parents or legal guardian to participate.

Athletics EMERGENCY INFORMATION

Please PRINT all information:

Name of athlete_____ Graduation Year _____

Name of Parent/Guardian_____Signature_____

Address_____

Primary Phone_____ Secondary Phone_____

Insured By_____ Policy Number_____

Family Doctor_____ Phone_____

Emergency Contacts if Parent/Guardian cannot be reached:
Name_____ Phone_____

Name_____ Phone_____

Name_____ Phone_____

IF CONTACT CANNOT BE MADE WITH ANY OF THE ABOVE, THE COACH WILL USE HIS/HER BEST JUDGEMENT TO PROTECT AND ASSIST THE INJURED IN ACCORDANCE WITH THE DENVER PUBLIC SCHOOL POLICY. I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR NOTIFYING THE SCHOOL IMMEDIATELY OF ANY CHANGES TO THIS INFORMATION.

CONTACT INFORMATION
(For schedule changes, team updates, and school information)

Parent Name:_____ Best Contact Phone #:_____

Cell Phone:_____Text? Email:_____

Student Name:_____ Best Contact Phone #:_____

Cell Phone:_____Text? Email:_____

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I understand that by signing below I have given permission to give out confidential information related to treatment records for my minor child/athlete that are protected by federal law (42 CFR, Part 2). I authorize that these records be released explicitely to the Denver Public Schools Sports Medicine (DPSSM) representative affiliated with my child's school. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to my child's DPSSM representative. If requested, I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will automatically expire 360 days from the date of my signature.
I understand that authorizing the disclosure of this health information is voluntary. I need not sign this section of this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand that a fee may be charged. A copy or facsimile of this authorization is to be considered as valid as the original. If I have questions about disclosure of my health information, I can contact the Health Information representative, Darryl Miller at (720)333-6371.

Athlete's Parent/Representative:_____ **Date:**_____

Parent/Representative printed name:_____**Athlete/Student name:**_____