



Valley Middle School



Valley School District Athletics

## ATHLETICS PARTICIPATION FORM

School Year: 20\_\_ / 20\_\_

### Permission to Participate

I hereby grant permission for my child, \_\_\_\_\_ to participate in the interscholastic athletics/sports listed below:

*(Please mark "X" in the box next to the sports your student wishes to participate in this school year.)*

- Football    
  Volleyball    
  Basketball    
  Baseball    
  Fast-pitch Softball

I understand that as a condition of participating, a physical examination and approval for participation by a licensed physician is required every 24 months. I agree to provide the physical activity clearance form to the school prior to the beginning of team practice when required. I further understand that upon serious student illness or injury requiring medical professional intervention, my student may not resume practice or competition until written approval for participation by a licensed physician is received by the school.

### Verification of Medical Insurance, Responsibility for Costs

I understand that my child cannot participate in interscholastic athletics unless my child is covered by the School Accident Coverage Plan, or a medical insurance plan provided by the family. I have marked the type of insurance that will cover my child for the duration of the school year below:

- I have purchased medical insurance through the "School Accident Coverage Plan" for this school year.  
 I have the following active medical insurance with coverage equivalent to or better than the Washington State Industrial Insurance fee schedule for medical services or hospitalization, and will continue to keep it activated throughout this school year.

Name of private insurance company: \_\_\_\_\_

Name of policy holder (person responsible for payment of fees): \_\_\_\_\_

Policy number: \_\_\_\_\_

- My household qualifies for the free or reduced-price meal program, and I need financial assistance for obtaining the School Accident Coverage Plan insurance. Please contact me to discuss my household's qualifications for assistance.

I assume financial responsibility for all costs of treatment for any injury which my child may undergo while participating in an interscholastic athletic program. I also understand that it is my responsibility to alert the school immediately if there has been a change in medical/accident insurance coverage for my child.

I have provided the school with emergency contact and family/student healthcare information. I affirm I have provided school authorities with authorization and consent for emergency medical treatment/care of my child if I cannot be reached to provide such consent (Form #3418F3).

I have reviewed the Athletic Code with my child. He/she understands the conduct expectations and academic standards and agrees to abide by these requirements.

***I certify that all information provided herein is correct, and that by signing this document I and my student have read, understand and agree to all terms, conditions, and information presented to me as required for my student's participation in Valley School District interscholastic athletics.***

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

Name of Parent/Guardian (please print): \_\_\_\_\_

FOR COACH/OFFICE USE ONLY

**Documents returned:**    
  Physical Confirmed/Date: \_\_\_\_\_    
  Medical Treatment Consent    
  Initial Grade Check OK  
 Safety Guidelines    
 Agreement/Assumption of Risk    
 Concussion    
 Sudden Cardiac Arrest