Connecticut Technical Education and Career System

Interscholastic Permission

School: Howell Cheney THS Date Received: _____

PARENT/GUARDIAN: PLEASE COMPLETE

This form plus a physical exam form must be on file with the School Nurse before the student may practice or play a sport. Physical exams are valid for 13 months from the date of the exam. A new permission form is also required every 13 months.

Section 1: To Be Completed by Student

Student Agreement:

Name: _____Date of Birth: _____

Class (YOG) : _____ Shop:_____ Sport(s):_____

This application to compete in supervised interscholastic athletics for the above school is entirely voluntary upon my part. I certify that I have not violated any of the eligibility rules and regulations of the Connecticut Interscholastic Athletic Conference (CIAC).

Signature of Student: _____ Date: _____

Section 2: To Be Completed by Parent/Guardian

Parent/Guardian's Permission: *I give my consent for the above student to participate in interscholastic athletics and accompany the team, as a member, on trips to any interscholastic games and consent to the necessary transportation for such trips.*

I understand that high school athletics involve the potential for injury which is inherent in any sport. I am aware that even with the best coaching, supervision, protective equipment and strict observation of the rules that there still is a potential for injury. On rare occasions, injuries could result in total disability or death.

Signature of Parent/Guardian:_____ Date:_____ E-mail address:_____

Home address:_____ Phone: (H)_____ (W)_____(C) _____
(Street address, city, zip code)

Emergency Contact #1 Info: Name _____ Relationship:_____

Address:_____ Phone: (H)_____ (W)_____(C) _____
(Street address, city, zip code)

Emergency Contact #2 Info: Name _____ Relationship:_____

Address:_____ Phone: (H)_____ (W)_____(C) _____
(Street address, city, zip code)

2020-2021

SCHOOL YEAR

Connecticut Technical Education and Career System
Interscholastic Athletics Medical History to be completed by Parent/Guardian

Name of Student: _____Grade:_____Date of Birth:_____

Does your Child have allergies? ☐ No ☐ Yes If yes, please list allergies: _____

Has your child had to carry a bee sting kit, Epi-pen, or other allergy medication?
☐ No ☐ Yes If yes, name medication _____

Does your child take medication every day? ☐ No ☐ Yes
If yes, name medicine: _____

Does your child have? ☐ Contacts ☐ Glasses ☐ Braces ☐ Loose Teeth ☐ False Teeth

Has your child ever had any of the following?

Asthma or use an inhaler or other medicine for asthma? ☐ No ☐ Yes
If yes, name of medication: _____

Kidney problems, only one kidney or kidney disease? ☐ No ☐ Yes
If yes, explain: _____

Problems with bruising or bleeding easily or trouble stopping breathing? ☐ No ☐ Yes
If yes, explain:_____

Seizures, Epilepsy or Convulsions? ☐ No ☐ Yes If yes explain _____
If yes, explain:_____

Diabetes, low blood sugar or high blood sugar? ☐ No ☐ Yes If yes explain _____

Fainting spells? ☐ No ☐ Yes If yes explain _____

Have a concussion. Head injury, been knocked out or unconscious? ☐ No ☐ Yes
If yes, explain:_____

High Blood Pressure or heart problems? ☐ No ☐ Yes If yes explain _____

A serious eye injury? ☐ No ☐ Yes If yes explain _____

A spine, neck or back injury? ☐ No ☐ Yes If yes explain _____

Bone, joint, neck or back pain? ☐ No ☐ Yes If yes explain _____

A broken bone, fracture, sprain or strain? ☐ No ☐ Yes
If yes explain _____

Ankle, foot or knee problems? ☐ No ☐ Yes If yes explain _____

An operation? ☐ No ☐ Yes If yes explain _____

Any other health problems? ☐ No ☐ Yes If yes explain _____

The medical history that I supplied is correct to the best of my knowledge

Signature of Parent/Guardian:_____ Date:_____