FEDERAL WAY PUBLIC SCHOOLS
Each Scholar: A voice. A dream. A **BRIGHT** future.

FEDERAL WAY PUBLIC SCHOOLS
INTRAMURAL/ELEMENTARY TRACK & FIELD PERMISSION FORM
For _____ School

_____ **Male___Female ___**

Last Name **First Name** **Grade Level**

_____

Address **City** **State** **Zip** **Email**

Please permit_____to participate in the intramural/elementary track activities program. I understand and acknowledge the following information concerning the program.

1. The school is unable to provide transportation unless otherwise instructed. Parents will be responsible for picking up those students normally bussed from school. Students normally walking from school may walk home after the program.

2. To get the most from the program, each child should be properly equipped with clothing appropriate for each activity.

3. Because of the strenuous nature of some of the activities, each student should have a physical exam. You should not permit your child to participate in these activities if they are not physically able to participate. Please consult your physician.

4. As the possibility of accident exists, every student is **required** to have accident insurance. An insurance program is offered through Federal Way Public Schools for students who do not have a family policy and wish to obtain coverage (those students with family coverage may purchase this additional insurance if they wish); forms are available in the school office.

I ACCEPT FULL RESPONSIBILITY FOR THE COST OF TREATMENT FOR ANY INJURY MY CHILD MAY SUFFER WHILE PARTICIPATING IN THE SCHOOL DISTRICT'S INTRAMURAL/ELEMENTARY TRACK PROGRAM.

_____

Parent/Guardian Signature Date

MEDICAL EMERGENCY AUTHORIZATION FORM #438
MUST BE COMPLETED BEFORE FIRST PRACTICE

To be completed by parent or guardian and returned to the coach.

Name of Student/Athlete:_____M_____F _____

Grade _____ Student ID#_____ Date of Birth _____

_____
Address City State Zip

As parent or legal guardian, I authorize the team physician or, in his/her absence, a qualified physician to examine the above-named student; and in the event of injury to administer emergency care and to arrange for any consultation by a specialist, including a surgeon, he/she deems necessary to insure proper care of any injury. Transportation will be arranged if deemed necessary by school or emergency personnel. Every effort will be made to contact the parent or guardian to explain the nature of the problem prior to any involved treatment or transportation.

Emergency Contact Person:

Name:_____ *Date:* _____
(Please Print) Parent or Guardian

_____
Parent/Guardian signature

Home Phone: ( )_____Business Phone: ( ) _____

Secondary Emergency Contact Person:

Name:_____Phone: _____

Family Physician's Name:_____Phone: _____

Hospital Preference: _____

Insurance company:_____Policy#_____

Student Medical History

	Yes	No	
1.	___	___	Are you allergic to any medications? Which: _____
2.	___	___	Do you take any medication regularly? Which: _____
3.	___	___	Do you have any chronic or recurrent illnesses? Which: _____
4.	___	___	Have you ever been hospitalized? When:_____Reason: _____
5.	___	___	Have you ever required an operation? When_____Reason: _____
6.	___	___	Have you ever had a concussion? When?_____Reason: _____
7.	___	___	Have you had a tetanus shot within the last 5 years? Date of last Shot: _____
8.	___	___	Do you wear glasses or contact lenses? (Circle)
9.	___	___	Do you wear any dental appliance such as a bridge, plate, braces or retainer? (Circle)
10.	___	___	Have you ever had asthma or breathing difficulties? Medications: _____
11.	__	___	Do you have any organs missing other than tonsils or appendix (eye, kidney, etc.)? _____
12.	__	___	Are you allergic to bee stings or other insect bites? What procedure should the school staff follow if this should occur? _____
13.			Are you currently taking ANY medications? (Including: vitamins, aspirin, etc.) What? _____