

**FEDERAL WAY PUBLIC SCHOOLS  
INTRAMURAL/ELEMENTARY TRACK & FIELD PERMISSION FORM**

<hr/>				Male ___	Female ___
<b>Student Name</b>	<b>Grade</b>	<b>School</b>			
<hr/>					
<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip</b>		
<hr/>					
<b>Date of Birth</b>	<b>Age as of 12/31/2015</b>	<b>Email Address</b>			

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? \_\_\_\_\_