Athletics Program Permission Slip

My child, _____, has permission to attend all practices and games for the sport(s) selected below. Participation in these events is limited to students of The Rhoades School. I understand that it is each family's responsibility to arrange for transportation for off-campus athletic events.

Sport: □ Co-ed Cross Country (September - November) - Grades 4-8
□ Girls Volleyball (September - November) - Grades 5-8
□ Boys Basketball (November - February) - Grades 5-8
□ Girls Basketball (February - May) - Grades 5-8
□ Co-ed Track & Field (February - May) - Grades 4-8

Grade (check one): □ 4th Grade □ 5th Grade □ 6th Grade □ 7th Grade □ 8th Grade

Parent/Guardian: Please check option 1 or option 2 to indicate the action desired in the event of an emergency.

Medical Authorization

1._____ I understand that while the Student is participating in an athletics event, an emergency may develop which necessitates medical attention. The Rhoades School will attempt to contact me prior to such treatments. I hereby authorize the School, through its staff and faculty, to act in my place in my absence and to give such authorization. This authorization is intended to give the staff of the School the right to give consent to authorize medical treatment for the Student.

I represent that the Student is in good physical condition and I am not aware of any disease or injury that might be aggravated or result in the Student being incapacitated or injured during a middle school social event.

2. _____ I do not choose the above statement and desire the following action:

_____

_____

If it is necessary for my son/daughter to return early from an athletic event, either because of illness or behavior, I understand that I am responsible for picking up my child from the event location.

General Release and Indemnification

I understand that participation in athletics events is entirely voluntary. I agree that in partial consideration of the School sponsoring the athletics events and permitting the Student to participate, I will not attempt to hold the School, Spring Education Group, and its or their respective officers, directors, employees, agents or volunteers liable in damages for any injury, death or loss to person or property sustained by the Student while participating in a athletics event. I have read this release, and understand that it affects legal rights and responsibilities, and I hereby agree and consent to its terms and conditions. By signing this form, I also agree for myself, my representatives and assigns, to release and hold harmless the Released Parties from any legal claim or liability for bodily injury and personal property damage that is caused to the Student while participating in an athletics event.

I understand that my child may be transported to practices via The Rhoades School van(s). I have read and recognize the Van Procedures and Policies.

Parent/Guardian Name (print): _____

Parent/Guardian Signature:_____

Date: _____ Emergency Phone Number: _____

Other Emergency Contacts

Name:_____ Relationship:_____ Phone Number:_____

Name:_____ Relationship:_____ Phone Number:_____

2021-2022 Team Sports Application

Student Name:_____ Grade: _____ Age: _____ DOB: _____

Address: _____ City: _____ Zip: _____

Parent/Legal Guardian Name:_____

Home #: _____ Cell #: _____ Work #:_____

Parent/Legal Guardian Email Address:_____

In case of emergency contact:

Contact #1 Name: _____ Contact #2 Name: _____

Cell #: _____ Cell #:_____

Email: _____ Email: _____

□ $425 Co-Ed Cross Country (Sept. - Nov.)	□ $425 Girls Volleyball (Sept. - Nov.)	□ $425 Boys Basketball (Nov. - Feb.)	□ $425 Girls Basketball (Feb. - May)	□ $425 Co-Ed Track & Field (Feb. - May)
			TOTAL:	

SPORTS UNIFORMS

Check One: □ Male □ Female

T-shirt size: □ Small □ Medium □ Large □ X-Large □ 2X-Large

Shorts size: □ Small □ Medium □ Large □ X-Large □ 2X-Large

HEALTH AND MEDICAL INFORMAITON

Allergies: _____

Medical Conditions:_____

Medications:_____

Physician Name:_____ Phone:_____

Health Insurance Carrier: _____ Group Name: _____

Group #: _____ Family/Individual #: _____

Dentist Name:_____ Phone:_____

Dental Insurance Carrier: _____ Group Name: _____

Group #: _____ Family/Individual #: _____

Parent Signature: _____ Date:_____

FOR OFFICE USE ONLY

PAYMENT RECEIVED: CHECK#: AMOUNT: □ REGISTERED □ RECORDED