Brice Christian Academy

Extracurricular Participation Release Form

Principal: Mrs. Angela Cover
3160 Brice Road, Brice, Ohio 43109
Office: (614) 866-6789/ Fax: (614) 861-4217

I hereby authorize the release and disclosure of the personal health information of _____ (student) to Brice Christian Academy. The information may be released to the school principal, athletic director, coach, athletic trainer, physical education teacher, school first aid provider, teacher, or other member of the school administrative staff as necessary to evaluate the student's eligibility to participate in school sponsored activities.

I understand that the school has requested this authorization to release or disclose the personal health information to make certain decisions about the student's health and ability to participate in certain school sponsored activities, and that the school is not a health care provider or health plan covered by federal HIPAA privacy regulations.

We, the parents / guardians of _____ , grant permission for our student to participate in extracurricular school sponsored activities at Brice Christian Academy. We further release the faculty, chaperones and drivers of any and all liability incurred from accidents or injuries resulting from such participation. We understand that these extra curricular activities are voluntary outside the bound of expected school experiences. Participation in extracurricular activities are a privilege, not a right. We grant permission to treat or have our child treated in case of injury or emergency.

I also understand that I have a responsibility to report my child's potential concussion symptoms to coaches, school administrators, and healthcare providers. I understand this may limit my student's participation, but is important for my student's long term health.

Note: This authorization must be signed by a parent or legal guardian to be valid. This authorization is valid for the current school year only (July 1st - June 30th). Students may not participate in any form until this signed release form has been recieved by the school office.

Parent / Guardian Signature_____ Date_____

Emergency Contact Information

Name:_____
Home #_____ Cell#_____
Medical Conditions to be aware of:_____
_____
Allergies (Please list all):_____
_____
Medications taken:_____
_____

Rcvd:_____

Student Code of Responsibility

As a BCA student, I understand and accept the following responsibilities:
I will respect the rights and beliefs of others and will treat others with courtesy and consideration.
I will be fully responsible for my own actions and the consequences of my actions.
I will respect the property of others.
I will respect and obey the rules of my school and laws of my community, state and country and those who are responsible for enforcing the rules and laws.
To reduce my risk of injury, I will obey all safety rules, follow a proper conditioning program, inspect their own equipment, and report any risks found to their coaches.
I understand all concussions are potentially serious and may result in complications if not recognized and managed properly. If I have a suspected concussion, I will not be allowed to participate until a required written authorization from a physician is provided to return to participation.
I understand I will not be permitted to participate until the school office receives this signed document.

Student Signature_____ Date_____

Sports Physical Form

Name:_____ Date of Birth:_____ Grade:_____

Date:_____ Sport(s): **ALL SPORTS - Basketball, Soccer, Track, Volleyball, WinterGuard**

Address:_____ Home Phone:_____

Guardian 1:_____ Work Phone:_____

Guardian 2:_____ Work Phone:_____

Emergency Contact:_____ Phone #:_____

Medical History

Significant Previous Injuries: ___ NO___YES _____

Hospitalizations or Surgeries: ___ NO___YES _____

Bone or Joint Injuries: ___ NO___YES _____

Current Medications: ___ NO___YES _____

Past Medications: ___ NO___YES _____

Chronic Illness: ___ NO___YES _____

Allergies: ___ NO___YES _____

Vaccinations are Current: ___ NO___YES _____

Seizures: ___ NO___YES Glasses or Contact Lenses: _____NO _____YES

Asthma: ___ NO___YES Fainting / Dizzy Spells: _____NO _____YES

Physical Exam

Height:_____ Weight:_____ Blood Pressure: _____

Feature	Result	Comments
General		
Eyes		
Nose		
Dental/Mouth		
Throat		
Ears		
Skin		
Cardiovascular		
Musculoskeletal		
Neurological		
Genitourinary		
Gastrointestinal		
Spinal		
Nutritional Status		
Mental Health		

Additional Comments:_____

I approve this student's participation in interscholastic sports for one (1) year. _____NO _____YES

Physician:_____ Signature:_____ Date:_____

Address:_____ Phone:_____

Office Use Rcvd:_____