

The Bromfield School

14 Massachusetts Avenue, Harvard, Massachusetts 01451
(978) 456-4152

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PLEASE CIRCLE ONE: Fall 08 Winter 08/09 Spring 09

Parents of Student Athletes:

We feel that you should know that the school does not provide insurance coverage for those students that represent The Bromfield School in interscholastic athletic competition. Accordingly, parents are required to ascertain that their own insurance coverage is sufficient to underwrite the cost of the medical care of any injuries that their child might sustain as a result of their participation in interscholastic athletics.

The school requires that every athlete is to be examined by a physician prior to participation in interscholastic athletics and that the student's tetanus booster is up-to-date. Please make arrangements with your family physician for this to be completed. **Documentation MUST be attached to this form for every sport your child participates in and returned to the Athletic Director prior to the start of the first practice session. Students will not be allowed to participate unless a current physical is attached (not on file).** Please make appointments as soon as possible.

Colleen Nigzus, R.N.
District School Nurse

Pam Alexander
Director of Athletics

Students Name: _____ **Grade:** _____ **Sport:** _____

List any known conditions your child has which may be pertinent to athletic participation:

Person to notify in case of emergency
if parent can't be reached

Phone #

Primary Care
Physician

Phone #

Consent for Medical Treatment (minor)

As a parent or legal guardian of the above named student, I hereby give my consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve life, limb, or well being of my dependent.

Injury Waiver

I hereby absolve The Bromfield School, including, but not limited to, it's coaches, assistant coaches, managers, and officers, from any and all liability resulting from injury sustained by the student listed above while participating in The Bromfield School's activity. I understand that injury is an inherent possibility in the activity for which I am registering my child. I understand the risk of injury is my responsibility.

Parent /Guardian Signature
(medical treatment and injury waiver)

Print Name

Date

To Be Completed By Physician

Student: _____

Date: _____

Blood Pressure:

Height: _____

HEENT:

Weight: _____

Neck:

Chest:

Heart:

Abdomen:

Scoliosis:

Genit:

Musculo Skeletal:

Nervous:

Skin:

Date of last Td injection: _____

Date of last MMR: _____

Date of Varicella: _____

Dates of Hepatitis: _____

May Participate in Athletics: _____ Yes _____ No

Needs further evaluation before participation may be permitted: _____

Reason: _____

Physician's Signature

Date

MD Phone # : _____

