

ORCHARD PARK CENTRAL SCHOOLS

INTERSCHOLASTIC PARENT PERMISSION FORM

I. ATHLETE INFORMATION

Athlete's Name: \_\_\_\_\_

Athlete's Address: \_\_\_\_\_  
(street, city, zip)

Athlete's Home Phone: \_\_\_\_\_ Parent Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Grade: \_\_\_\_\_ for school year 20\_\_\_\_/20\_\_\_\_ Date of birth: \_\_\_\_\_ Gender: \_\_\_ M \_\_\_ F

I have read the Orchard Park Athletic Eligibility Rules, Code of Conduct, and Concussion Management Information. I understand that participation in school athletics is a privilege. Given this, I agree to observe all school rules and further, I agree to represent my team well in the school and community by displaying appropriate conduct.

**NEW TO DISTRICT?**  
\_\_\_\_\_ no \_\_\_\_\_ yes, registration date: \_\_\_\_\_

\_\_\_\_\_  
Athlete Signature

II. PARENTAL PERMISSION

1) I hereby give permission for my son/daughter noted above to participate in the interscholastic sport and conditioning programs of:

VARSITY  JV  FRESHMAN  MODIFIED \_\_\_\_\_  
(boys/girls/coed) (sport)

I have read and understand the eligibility rules and understand the expectations of Orchard Park student athletes. I understand that athletic participation is a privilege (not a right). *I understand that if the district believes it appropriate, the district may limit, prevent, or halt my child's athletic participation, provided my child fails to meet or abide by school/eligibility rules, the student code of conduct or if my child poorly represents his/her team by displaying inappropriate student athlete conduct in the school /community.* I agree to do everything possible to help my son/daughter abide by these Orchard Park CSD student athlete expectations, including the expectation of appropriate conduct.

2) Health Insurance Carrier: \_\_\_\_\_ HGT.: \_\_\_\_\_ WGT.: \_\_\_\_\_

3) Please complete the following and if yes, please describe:

- Any injuries or operations? Yes  No
- Any illness lasting more than 5 days? Yes  No
- Taking any medicine or under physician's care? Yes  No
- Faintness, dizziness or fatigue after exertion? Yes  No
- Any physical disease or other difficulty that affects participation: Yes  No

Description: \_\_\_\_\_

4) I have read and reviewed with my child the Concussion Management and Awareness Information available on the OPCSD website or the State Education website. Yes  No

5) I give consent for my child to receive baseline cognitive testing with ImPact Concussion Management software, at the District's discretion. Yes  No

6) Parent's signature: \_\_\_\_\_ Parent's name: \_\_\_\_\_ Date: \* \_\_\_\_\_  
Please print \*no earlier than 30 days prior to practice

III. SCHOOL USE ONLY

Physical administered on: \_\_\_\_\_ Update on: \_\_\_\_\_

Overall review by: \_\_\_\_\_ Date: \_\_\_\_\_  
School doctor, nurse or school health official signature