



# TRADERS POINT CHRISTIAN ACADEMY

Dear TPCA Parents/Guardians,

The **Student's Health Record Packet** must be completed annually for each student and placed in the health record prior to the first day of school. Please read and complete each document thoroughly and include the most accurate and up-to-date health information available to ensure your child's health and safety. Each of these forms is also available on the TPCA website. **Please submit this packet as soon as possible and no later than August 10, 2011 to allow for review and appropriate planning prior to the first day of school.**

**-Student Medical Contact & Emergency Information Form (ALL Students)**

An additional **Individualized Health Plan (IHP)** and/or an **Emergency Action Plan (EAP)** completed by the *physician* will be required for each student with a *physician* diagnosed medical or chronic health condition such as diabetes, anaphylactic allergy, asthma, in addition to other challenges as determined by TPCA. (IC-34-5-12) Please, contact the treating *physician* for a current EAP and submit with your child's other Health Record Packet documents. Forms are also available from the school nurse.

**-Student Immunization Record (submit only for K & 6<sup>th</sup> grades or new/transferred student and ALL Early Childhood/Preschool Classes)**

You may either have your physician utilize the TPCA form provided or provide a copy of the physician's immunization record for the student. If not received by the first day of school the student may be prohibited from returning to school. (IC 20-34-4-2)

**-CHIRP Consent and Release Form (ALL Students)**

Children and Hoosiers Immunization Registry Program (CHIRP) is a free and innovative online system that stores and updates immunization records of both children and adults in Indiana. It is confidential and secure. It reduces under and over immunization of patients by viewing consolidated immunization records from multiple providers and can provide an official immunization card with the child's up-to-date immunization history. (IC 16-38-5-3)

**-Religious Objection Form (only if you have a religious objection to immunizations) (IC 20-34-3-2)**

**-Student OTC Medication Permission Form (ALL Students)**

In an effort to better serve our families a few OTC medications are available to students who have a permission form completed and on file. If the form is not completed your child will not have access to OTC medication while at school. (IC 20-34-3-6 & IC 34-30-14-2)

An additional **Student Medication Permission Form** is required for each prescription medication that is required to be taken by the student during school hours. Parents must present the medication to the school nurse and complete the form at that time. **Parents will be telephoned to return to school and pick-up any medication brought in by a student.**

An additional **Student Possession and Self-Carry Medication Form** must be completed by a *physician* for any medication that meets this designation. Form available from the school nurse. (IC 20-33-8-12 & IC 20-34-5) Please, refer to the **TPCA Medication Policy** included in this packet.

**-Student Health History and Physical Examination Form (ALL Students-non-athletes and athletes)**

An annual physical examination by a physician helps determine if the student is having a physical challenge that may prevent the student from receiving the full benefit of the student's school work, participating in physical education, recess, field trips, athletics, etc. (IC 20-24-3-4, IC 20-34-3-5 & IC 20-34-3-9)

**Both the Health History Form and the Physical Examination Form are to be completed for ALL students. Where there is a designation for "athlete" or "sports" on the Health History Form or Physical Examination Form this designation represents both non-athletes and athletes and physical education/recess and sports, respectively.**

**-Preparticipation Sports Consent and Release Form (only if student participating in sports)**

This form must be completed for every student before participating in any athletic sport.

Thank you and Blessings,

Jayne Rookberry-Price BSN, RN, TPCA Nurse, Extension 244

Amy Berens, Athletic Director, Extension 234



# TRADERS POINT CHRISTIAN ACADEMY

## 2011-12 Student Medical Contact and Emergency Information

**All Students Annually**

Student's Legal Name: \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_\_ Grade: \_\_\_\_\_

Persons will be contacted in order of designation below, 1-4, until someone is reached.

Local Emergency Contacts		
Name & Relationship to Student	Phone Numbers	
1. Parent/Guardian	Cell: Work:	Home: Other:
2. Parent/Guardian	Cell: Work:	Home: Other:
3. Local Emergency Contact/Relationship	Cell: Work:	Home: Other:
4. Local Emergency Contact/Relationship	Cell: Work:	Home: Other:

Name of family doctor: \_\_\_\_\_

Phone number: \_\_\_\_\_

Name of student's dentist: \_\_\_\_\_

Phone number: \_\_\_\_\_

Preferred hospital: \_\_\_\_\_

Date of last tetanus shot: \_\_\_\_\_

Allergies please explain what type of allergies, reactions, and what precautions need to be taken while at school: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Chronic Health Problems please explain any health conditions and special instructions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List All Medications use back side for more room; please specify if medications will be taken at home and/or school:

Name	Dosage	Frequency	Times Taken	Purpose	Taken at Home/School
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

\_\_\_\_\_

\_\_\_\_\_

In case of an emergency involving your child, it is the policy of TPCA to render first aid treatment while contacting parents/guardians for further instructions. In the event that the parents/guardians cannot be contacted, designated employees of TPCA will see that the child is transported to the nearest clinic or hospital (unless indicated otherwise below). Once there, the employee will authorize medical treatments or procedures that, in the opinion of the attending physician, are necessary for the child's safety. (e.g. x-rays, anesthetic, medical or surgical diagnosis or treatment). This step will be taken only after all emergency contacts have been exhausted or if the school has received no instructions in a reasonable amount of time. Information on this form may be shared with the appropriate TPCA and EMS personnel for health and emergency purposes.

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_



# TRADERS POINT CHRISTIAN ACADEMY

## 2011-12 Student Immunization Record

*Only if entering grades K & 6 or new/transferred student and  
All Early Childhood/Preschool Classes*

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Vaccine	1	2	3	4	5
DTap/DT/Td					
Hepatitis B					
Hib					
HPV					
IPV or OPV					
MCV4					
MMR					
PCV7					
Tdap [Adult]					
Varicella*					

\*or month/year of disease

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

### 2011-12 ISDH School Immunization Requirements (IC 20-34-4-2)

Each school shall require the parent of a student who has enrolled to furnish no later than the **first day of school** a written statement of the student's immunization, accompanied by the physician's certificate unless exempt under IC 20-34-3-2-Religious Objection or IC 20-34-3-3-Exception for Student's Health (IC 20-34-4-5)

<p><b>Age 3-5 years:</b>  <b>4 DTap</b> (Diphtheria, Tetanus &amp; Pertussis)  <b>3 Hep B</b> (Hepatitis B)  <b>3 IPV/OPV</b> (Polio)  <b>1 MMR</b> (Measles, Mumps &amp; Rubella)  <b>1 Varicella</b> (Chicken Pox)</p>	<p><b>Grades K-1:</b>  <b>5 DTap</b> (Diphtheria, Tetanus &amp; Pertussis)  <b>3 Hep B</b> (Hepatitis B)  <b>4 IPV/OPV</b> (Polio)  <b>2 MMR</b> (Measles, Mumps &amp; Rubella)  <b>2 Varicella</b> (Chicken Pox)</p>
<p><b>Grades 2-5:</b>  <b>5 DTap</b> (Diphtheria, Tetanus &amp; Pertussis)  <b>3 Hep B</b> (Hepatitis B)  <b>4 IPV/OPV</b> (Polio)  <b>2 MMR</b> (Measles, Mumps &amp; Rubella)  <b>1 Varicella</b> (Chicken Pox)</p>	<p><b>Grades 6-12:</b>  <b>5 DTap</b> (Diphtheria, Tetanus &amp; Pertussis)  <b>3 Hep B</b> (Hepatitis B)  <b>4 IPV/OPV</b> (Polio)  <b>1 MCV4</b> (Meningococcal)  <b>2 MMR</b> (Measles, Mumps &amp; Rubella)  <b>1 Tdap</b> (Tetanus, Diphtheria &amp; Pertussis) [Adult]  <b>2 Varicella</b> (Chicken Pox)</p>



# TRADERS POINT CHRISTIAN ACADEMY

## 2011-12 CHIRP Form

**All Students Annually**

I, \_\_\_\_\_, *DO or DO NOT* (circle one designation)

give Traders Point Christian Schools, Inc. permission to release the following information concerning

my child, \_\_\_\_\_,

to the Indiana State Department of Health's Children and Hoosiers Immunization Registry Program (CHIRP):

- Child's Name
- Immunization Data
- Date of Birth
- Demographic Data, including but not limited to:
  - Parent/Guardian Name (s)
  - Address
  - Phone Number
  - Race/Ethnic Background

I understand that the information in the registry may be used to verify that my child has received proper immunizations and to inform me or my child of my child's immunization status or that an immunization is due according to recommended immunization schedules.

I understand that my child's information may be available to the immunization data registry of another state, a healthcare provider or a provider's designee, a local health department, an elementary or secondary school, a child care center, the office of Medicaid policy and planning or a contractor of the office of Medicaid policy and planning, a licensed child placing agency, and a college or university. I also understand that other entities may be added to this list through amendment to I.C. 16-38-5-3.

I hereby consent to the release of such information.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Address

(\_\_\_\_\_) \_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Child's Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
School

\_\_\_\_\_  
Grade Level



# TRADERS POINT CHRISTIAN ACADEMY

## **2011-12 Religious Objection**

**Only if you have religious objections to immunizations**

Student's Name: \_\_\_\_\_

Grade: \_\_\_\_\_

In accordance with Indiana immunization laws, specifically IC 20-34-3-2, based on religious grounds, I/we choose not to immunize my/our child named above to the specified immunizations:.

\_\_\_ Diphtheria

\_\_\_ Measles

\_\_\_ Pertussis

\_\_\_ Mumps

\_\_\_ Tetanus

\_\_\_ Rubella

\_\_\_ Polio

\_\_\_ Hepatitis B

\_\_\_ Meningitis

\_\_\_ Varicella

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\*If only one parent/guardian signature obtained, please indicate reason.



**2011-12 Student Over-The-Counter Medication Permission Form**

**All Students Annually**

Name: \_\_\_\_\_ Grade: \_\_\_\_\_

**In an effort to better serve our families, Over-The-Counter (OTC) medications are available to students who have an OTC Medication Permission Form signed/initialed by the parent and on file in the nurse's office. If this form is not on file your child will not be dispensed an OTC medication.**

Only the medications listed below will be available and only the amount recommended on the label will be dispensed from the nurse's office. If your primary care physician has prescribed an amount exceeding the label recommendations a prescription will be required from the physician.

You must sign the bottom portion of this form and initial which medications you have given permission for your child to receive. **Medication will not be dispensed to your child unless this document is signed and only for medications with corresponding initials.**

(IC 20-34-3-6 & IC 34-30-14-2)

\_\_\_\_\_ **Acetaminophen (Tylenol) 500 mg tablet or 160mg/5ml liquid suspension every 4-6 hours as needed for minor aches, pains and fever.**

**Uses:** headache, backache, muscular aches, common cold, toothache and menstrual cramps.

Medication will no longer be dispensed if pain worsens or lasts for more than 10 days or fever lasts more than 3 days. A doctor must be consulted to receive additional medication.

\_\_\_\_\_ **Ibuprofen (Motrin/Advil) 200 mg tablet or 100mg/5ml liquid suspension every 6-8 hours as needed for minor aches, pains and fever.**

**Uses:** headache, backache, muscular aches, common cold, toothache, and menstrual cramps.

Medication will no longer be dispensed if pain worsens or lasts for more than 10 days or fever lasts more than 3 days. A doctor must be consulted to receive additional medication.

\_\_\_\_\_ **Calcium Carbonate (Tums) 750mg chewable tablet every hour not to exceed 10 tablets in a 24 period as needed for stomach discomfort.**

**Uses:** acid indigestion, heartburn and sour stomach.

Medication will no longer be dispensed if discomfort last more than 2 weeks. A doctor must be consulted to receive additional medication.

\_\_\_\_\_ **1% Hydrocortisone Cream as needed for minor skin irritation, itching and rashes 3-4 times daily.**

**Uses:** inflammation and rashes due to eczema, insect bites, poison ivy, poison oak, poison sumac, soaps, detergents, cosmetics, jewelry, seborrheic dermatitis and/or psoriasis.

Medication will no longer be dispensed if condition worsens or symptoms persist for more than 7 days or clear up and occur again within a few days. A doctor must be consulted to receive additional medication.

\_\_\_\_\_ **Throat Drop (Halls) with mentho-lyptus for sore throat and/or cough.**

\_\_\_\_\_ **Decline OTC Medications. My child should NOT receive any over-the-counter (OTC) medication.**

\_\_\_\_\_  
Parent/Guardian Signature/Initials

\_\_\_\_\_  
Date



## 2011-12 Medication Policy

The following information addresses the dispensing of medication according to Indiana law and school policy (IC 20-34-3-18, IC 20-34-3-6 & IC 34-30-14-2):

- **Medications needed while at school must be brought by an adult to the clinic to be dispensed. No medications may be carried by the student at school.** Disciplinary policy will be followed if students are found to have medications on campus or share medications with another student. **Parents will be telephoned to return to school and pick-up any medication brought in by a student.**
- **Note:** Students requiring self-administration for Anaphylaxis, Asthma and/or Diabetes are allowed to carry them at school if a **Possession and Self-Carry Permission Form** is completed by the prescribing doctor, and the medication is labeled with the pharmacy label.
- Any prescription drug must have a current pharmacy label on the container. (Pharmacists will usually provide an extra labeled bottle, upon request, for this purpose. It is helpful if the dose is measured out for school-time administration and the rest kept at home.)
- A **Medication Permission Form** must be signed by the parent/guardian for any medication before it can be dispensed at school. This form is available from the nurse. The parent will need to complete the form when bringing the medication to the nurse for safe storage and dispensing. **Parents will be telephoned to return to school and pick-up any medication brought in by a student.**

**Include:** Name of medication, dosage & frequency, student's name, date. The medication must be in the original container/blister pack.

- Medications that can only be given every 12 or 24 hours shall be given at home. Those medications will not be accepted to be given at school.
- No vitamins or herbal supplements will be dispensed at school for liability reasons. Only medications that are FDA approved will be allowed.

The clinic stocks Acetaminophen (Tylenol), Ibuprofen (Advil, Motrin), chewable antacid (TUMS), throat drops, and hydrocortisone cream. If you would like your student to receive one of these medications from the school personnel, please sign and return the Over-The-Counter Permission Form to the school office. No medication will be dispensed without parental permission.

Many of the medication forms can be found on the school website. Any medication being dispensed at school must be brought into school by an adult and presented to the school nurse. **If your child will have more than one medication at school one form needs to be completed for each medication.** If you have questions or would like to donate some of the needed over-the-counter medications please do not hesitate to contact the school nurse during schools hours.

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam \_\_\_\_\_

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

**Medicines and Allergies:** Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have any allergies?     Yes     No    If yes, please identify specific allergy below.

Medicines                                       Pollens                                       Food                                       Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease                              Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	Yes	No
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete \_\_\_\_\_

Signature of parent/guardian \_\_\_\_\_

Date \_\_\_\_\_

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

**PHYSICIAN REMINDERS**

- Consider additional questions on more sensitive issues
  - Do you feel stressed out or under a lot of pressure?
  - Do you ever feel sad, hopeless, depressed, or anxious?
  - Do you feel safe at your home or residence?
  - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
  - During the past 30 days, did you use chewing tobacco, snuff, or dip?
  - Do you drink alcohol or use any other drugs?
  - Have you ever taken anabolic steroids or used any other performance supplement?
  - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
  - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION						
Height	Weight	<input type="checkbox"/> Male <input type="checkbox"/> Female				
BP / ( / )	Pulse	Vision R 20/	L 20/	Corrected	<input type="checkbox"/> Y <input type="checkbox"/> N	
MEDICAL		NORMAL	ABNORMAL FINDINGS			
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)						
Eyes/ears/nose/throat • Pupils equal • Hearing						
Lymph nodes						
Heart <sup>a</sup> • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)						
Pulses • Simultaneous femoral and radial pulses						
Lungs						
Abdomen						
Genitourinary (males only) <sup>b</sup>						
Skin • HSV, lesions suggestive of MRSA, tinea corporis						
Neurologic <sup>c</sup>						
MUSCULOSKELETAL						
Neck						
Back						
Shoulder/arm						
Elbow/forearm						
Wrist/hand/fingers						
Hip/thigh						
Knee						
Leg/ankle						
Foot/toes						
Functional • Duck-walk, single leg hop						

<sup>a</sup>Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

<sup>b</sup>Consider GU exam if in private setting. Having third party present is recommended.

<sup>c</sup>Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- Cleared for all sports without restriction
- Cleared for all sports without restriction with recommendations for further evaluation or treatment for \_\_\_\_\_
- Not cleared
- Pending further evaluation
- For any sports
- For certain sports \_\_\_\_\_
- Reason \_\_\_\_\_
- Recommendations \_\_\_\_\_

**I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).**

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO



# TRADERS POINT CHRISTIAN ACADEMY

## 2011-12 Preparticipation Sports Consent and Release Form

### I. STUDENT ACKNOWLEDGMENT AND RELEASE CERTIFICATE

- A. I certify that I understand the rules set forth by my school in order to participate in athletic programs and know of no reason why I am not eligible to represent my school in athletic competition.
- B. If accepted as a representative, I agree to the rules and abide by the decisions of my school.
- C. I know that athletic participation is a privilege. I know of the risks involved in athletic participation, understand that serious injury, and even death, is possible in such participation, and choose to accept such risks. I voluntarily accept any and all responsibility for my own safety and welfare while participating in athletics, with full understanding of the risks involved, and agree to release and hold harmless Traders Point Christian Schools, Inc./Traders Point Christian Academy, its agents, and employees from any and all responsibility and liability, including any from their own negligence, for any injury or claim resulting from such athletic participation and agree to take no legal action against my school or the schools involved because of any accident or mishap involving my athletic participation.

**I HAVE READ THIS CAREFULLY AND KNOW IT CONTAINS A RELEASE PROVISION.**

Student's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

### II. PARENT/GUARDIAN CONSENT, ACKNOWLEDGMENT, AND RELEASE CERTIFICATE

- A. I/we hereby give consent for my son/daughter/me to participate in the following interschool sports **CIRCLED**:  
**Boys Sports:** Baseball, Basketball, Cross Country, Football, Soccer, Tennis, Track  
**Girls Sports:** Basketball, Cheerleading, Cross Country, Soccer, Tennis, Track, Volleyball.
- B. I/we understand that participation may necessitate an early dismissal from classes.
- C. I/we know of and acknowledge that my son/daughter knows of the risks involved in athletic participation, understand that serious injury, and even death, is possible in such participation and choose to accept any and all responsibility for his/her/my safety and welfare while participating in athletics. With full understanding of the risks involved, I/we release and hold harmless Traders Point Christian Schools, Inc./Traders Point Christian Academy, its agents, and employees from any and all responsibility and liability, including any from their own negligence, for any injury or claim resulting from such athletic participation and agree to take no legal action against the schools involved because of any accident or mishap involving my son's/daughter's athletic participation.
- D. I/we have listed below any medical conditions that my child has which may be relevant to a physician in the event of an emergency. In the event an emergency occurs, I may be reached at the phone number listed below. If I cannot be reached, I hereby authorize the adult coaches and sponsors to make emergency medical decisions for my child.
- E. I/we expressly agree that this release, waiver and indemnity agreement is intended to be broad and inclusive as permitted by the law of the state of Indiana, and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect. This release contains the entire agreement between the parties hereto, and the terms of this release are contractual and not a mere recital. I/we further state that I have carefully read the foregoing release and know the contents thereof, and I/we sign this release as my/our own free act. This is a legally binding agreement which I/we have read and understand.

**I HAVE READ THIS CAREFULLY AND KNOW IT CONTAINS A RELEASE PROVISION.**

(To be completed and signed by all parents/guardians, emancipated students; where divorce or separation, parent with legal custody must sign)

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Pertinent Medical Conditions/Information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_