AUBURN HIGH SCHOOL
CLEARANCE FOR ATHLETIC TEAM PARTICIPATION

NAME: ______________________________ DATE OF BIRTH ________________

ADDRESS: ______________________________ TELEPHONE: ________________

PARENT E-MAIL ADDRESS: ________________________

I give permission for my e-mail address and contact information to be shared with the Athletic Booster Club for the sole purpose of receiving information regarding the athletic program or activities of the Athletic Booster organization.

YEAR OF GRADUATION: ____________________

THIS IS TO CERTIFY THAT MY SON/DAUGHTER HAS MY PERMISSION TO PLAY ______________
(SPORT)

HE/SHE HAS INSURANCE COVERAGE AS FOLLOWS:

NAME OF INSURER ____________________________ NO INSURANCE ☐

WILL BE RESPONSIBLE FOR THE FULL COST OF ANY ATHLETIC EQUIPMENT ISSUED TO HIM/HER THAT IS LOST OR DAMAGED.

PARENT/GUARDIAN SIGNATURE: ____

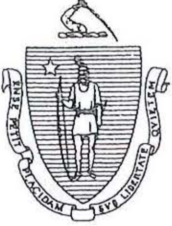
Parent signature indicates that you have visited the MIAA website (www.miaa.net) and familiarized yourself with the new concussion laws. **PLEASE COMPLETE AND SIGN THE ATTACHED FORMS**

STUDENT SIGNATURE: ____

PHYSICAL EXAM – SCHOOL NURSE SIGNTURE: ______________________________
Current Physical Exam on file

ATHLETIC DIRECTOR'S SIGNATURE: ______________________________________

Student athletes must complete this form and obtain the proper signatures prior to participation in any athletic program. The completed form is to be handed to the coach before participation.



The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
250 Washington Street, Boston, MA 02108-4619

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

JUDYANN BIGBY, MD
SECRETARY

JOHN AUERBACH
COMMISSIONER

PRE-PARTICIPATION HEAD INJURY/CONCUSSION REPORTING FORM FOR EXTRACURRICULAR ACTIVITIES

This form should be completed by the student's parent(s) or legal guardian(s). It must submitted to the Athletic Director, or official designated by the school, *prior* to the start of each season a student' plans to participate in an extracurricular athletic activity.

Student's Name	Sex	Date of Birth	Grade
School		Sport(s)	
Home Address			Telephone

Has student ever experienced a traumatic head injury (a blow to the head)? Yes________ No________

If yes, when? Dates (month/year): ______________________________

Has student ever received medical attention for a head injury? Yes______ No_______

If yes, when? Dates (month/year): ______________________________

If yes, please describe the circumstances:

Was student diagnosed with a concussion? Yes_______ No______

If yes, when? Dates (month/year): ______________________________

Duration of Symptoms (such as *headache, difficulty concentrating, fatigue*) for most recent concussion: ______________

Parent/Guardian:
Name: ______________________________ Signature/Date ______________________________
(Please print)

Student Athlete:
Signature/Date ______________________________

over →

Auburn High School
Athletic Training
Consent to Treat & Emergency Care Information

Student Athlete's Name: ____________________ Grade: ____ Sport(s): ______________

1. The undersigned athlete or guardian consents to the rendering of medical and allied health care at Auburn High School which may include acute care, medical and rehabilitation treatment, and emergency care procedure if necessary.
2. The athlete or guardian acknowledges that no guarantees will be made as the result of evaluation or treatment.
3. The athlete or guardian understands:
   A. Each athlete or guardian has the right to consent or refuse consent to any proposed procedure or therapeutic course.
   B. In the event where a physician's opinion and treatment is needed, the athlete cannot return to athletic participation until clearance is given by such health care professional.
   C. In accordance with Massachusetts state law, in the event of a concussion, the athlete must seek outside medical diagnosis and clearance before returning to athletic participation. Massachusetts's DPH Pre-participation concussion history form must be turned in prior to athletic season. All athletes diagnosed with a concussion must complete return-to-play protocol before returning to sports.
   D. Emergency medical treatment may be necessary as a result of athletic participation. In the event that a guardian or emergency contact cannot be reached, the signature below provides consent to advance with emergency care and assumes such expenses.
4. The athlete or guardian understands the below medical history is to provide the athlete with the upmost care during athletic participation and will only be seen by the athletic trainer. Providing the information below is optional yet encouraged.

Allergies: ____

Medical condition/concern that may affect athletic participation: ______________

____

Emergency Contact: ______________________ Phone: ______________

I hereby accept and agree to abide by the above procedures and regulations of Auburn High School athletic training facility.

Athlete signature (if over 18): __________________________ Date: __________

Parent/Guardian signature: __________________________ Date: __________

Any questions/concerns contact Emily Para, ATC at epara@auburn.k12.ma.us 508-832-7711 ext 1011