

**DUBLIN CITY SCHOOLS  
ATHLETIC RESPONSIBILITY ACKNOWLEDGMENT**

ATHLETE'S NAME (LAST, FIRST) \_\_\_\_\_

GRADE \_\_\_\_\_

STUDENT'S EMAIL ADDRESS \_\_\_\_\_

Prior to participating in any practice or tryout sessions for any interscholastic sport, the following must occur.

1. Student must have a current physical exam given by a registered physician and it must be on file with the coach or trainer.
2. Student must return this Athletic Responsibility Acknowledgment Form to his/her coach and it must be properly signed.
3. Student must properly complete and return the Emergency Medical Form to the coach.

As a Dublin Schools student athlete participating voluntarily in interscholastic athletics,

1. I will abide by the rules and policies of the Dublin Schools, team rules, and the rules of the Ohio High School Athletic Association.
2. I will conduct myself in an exemplary manner at all times and will be a positive example for others.
3. I will be responsible for all athletic equipment issued to me throughout the season, will return such equipment at the conclusion of the season, and will pay the current replacement cost for any of the equipment damaged or lost.
4. I acknowledge that I have been properly advised, cautioned and warned that participation in interscholastic athletics can lead to possible injuries. Although most injuries are minor in nature, it is possible that an injury could occur that is severe enough to cause me to become paraplegic, quadriplegic, or result in death. Every effort will be taken to prevent such injuries, but I understand that such risk does exist. Having been so cautioned and warned, it is still my desire to participate in sports and to do so with full knowledge and understanding of the risk of injury.
5. I, along with my parents, certify that I did receive a copy of the athletic handbook, understand all of the information contained in the athletic handbook, and in order to be eligible for participation I must comply with all requirements listed.

Student Signature \_\_\_\_\_

Date \_\_\_\_\_

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

Date \_\_\_\_\_

**INSURANCE INFORMATION**

[Please sign only one (1) of the insurance sections that follow.]

**SECTION (A) INSURANCE WAIVER - for those WITHOUT ACCIDENT INSURANCE**

We, the parents or guardians of the student above hereby acknowledge that an accident policy **IS NOT** in force for our son/daughter that will pay the medical or surgical expense that results from an injury, major or minor, that the above named student may receive as a result of practicing or performing in athletics at the Dublin Schools. Since we, the parents or guardians of the above named students **DO NOT** have an insurance policy which will provide adequate financial coverage for any type of injury or injuries or whatever might result, we, the parents or guardians agree to release the Dublin City School District, or any part thereof, from any obligation as pertains to financial responsibility in these matters for the current school year or any period of the time thereafter.

Date \_\_\_\_\_

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

**SECTION (B) INSURANCE VERIFICATION - for those WITH ACCIDENT INSURANCE**

We, the parents or guardians of the above named students **HAVE** insurance with:

Company \_\_\_\_\_

Policy Number \_\_\_\_\_

This policy will pay the medical or surgical expenses that result from any injury, major or minor, that the above named student may receive as a result of practicing or performing in athletics in the Dublin Schools. This insurance will also cover the above named student while traveling to or from practice sessions or scheduled performances. Since, we, the parents or guardians of the above named student, have an insurance policy which will provide adequate financial coverage for any type of injury or injuries or whatever might result therefrom, we, the parents or guardians agree to release Dublin Schools or any part thereof, from any obligation as pertains to financial responsibility in these matters for the current school year or any period of the time thereafter.

Date \_\_\_\_\_

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



# Dublin City Schools Emergency Medical Authorization Form

Student  
5341 F1  
Rev. 6/7/06

**\*Complete Both Sides**

Student Name: \_\_\_\_\_  
(Last Name) (First Name) (Middle Initial)

Home Address: \_\_\_\_\_  
(Street) (City/State/Zip) (County)

School Attending: \_\_\_\_\_ Teacher/Team: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent(s)/Guardian with whom student resides: \_\_\_\_\_

Mother: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Father: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

\*Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.  
\*This information will be shared with staff and emergency care providers if needed.

*In the event you cannot be reached, list two local people to whom you authorize the school to release your ill or injured child.*

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

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Relationship to Student: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

*Please list facts concerning the child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted.*

Allergies: \_\_\_\_\_  
(List what your child is allergic to) (Type of reaction) (Usual treatment)

Medical Condition: \_\_\_\_\_

Medications/Treatment: \_\_\_\_\_ Physical Impairments: \_\_\_\_\_

*According to ORC 3313.712, a legal parent/guardian must sign either the Consent for Treatment or the Refusal to Consent for Treatment. Please sign one:*

### **OPTION I: CONSENT FOR TREATMENT**

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_ Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical Specialist: \_\_\_\_\_ Phone: \_\_\_\_\_ Local Hospital: \_\_\_\_\_ Phone: \_\_\_\_\_

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctor, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Parent/Guardian Signature: \_\_\_\_\_ Address: \_\_\_\_\_ Date: \_\_\_\_\_

### **OPTION II: REFUSAL TO CONSENT FOR TREATMENT**

I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

\_\_\_\_\_  
Parent/Guardian Signature: \_\_\_\_\_ Address: \_\_\_\_\_ Date: \_\_\_\_\_