Bellefonte Area School District Intramurals

_____

(Activity)

All students in grades _____ are welcomed to join us for intramurals! Intramurals are a great way to have fun, make friends, improve skills, and learn good sportsmanship in a noncompetitive atmosphere. _____ will be leading the activities. This season's activity is _____, and will take place during the following days/times:

Day	Date	Begin Time	End Time

Parents who are picking up their child should plan to arrive at the school a few minutes early. Please indicate how your child will be getting home below. In the event of inclement weather necessitating cancellation of the day's activities, the students will be notified by 1:00PM that day. Please discuss with your child what he/she should do in the event that the activity is cancelled.

Student Name:_____Grade:_____School:_____

ACKNOWLEDGEMENT OF RISK

As with any physical activity, I am aware that with the participation in sports there lies a potential risk of injury. I am aware that giving consent to my child for participation in the intramural program there is a risk of injury to my child and this risk increases with participation in contact sports.
I acknowledge and accept the risks inherent in my child's participation. With this knowledge in mind, I grant permission for my child to participate in the Bellefonte Area School District's intramural program.

Parent/Guardian Signature _____

PLEASE INDICATE HOW YOUR CHILD WILL BE GETTING HOME AFTERWARDS (such as you (or someone you know) will be picking them up, they will be walking home, driving, etc.):

_____.

Please NOTE: Student medications stored in the Health Room are not available during intramural activities, please make arrangements, if needed.

BELLEFONTE AREA SCHOOL DISTRICT INTRAMURAL CONSENT FOR EMERGENCY MEDICAL TREATMENT

*Student's name:*_____ *Birthdate:* _____ *Date:* _____
In the event of an emergency requiring medical attention, I expect every measurable attempt be made to contact me. In case I cannot be reached, I grant permission for any immediate treatment deemed necessary by the Intramural activity supervisor. I expect every effort will be made to contact me in order to receive my specific authorization before any treatment or hospitalization is undertaken.
This authorization does not cover major surgery unless formally decreed prior by two licensed physicians or dentists.
Facts concerning my child's medical history including allergies, medications being taken and physical impairments to which medical personnel should be alerted to:

_____
_____

Check One: _____ I GIVE MY CONSENT *OR* _____ *I DO NOT GIVE MY CONSENT*
*Parent/Guardian Signature:*_____
Cell:_____
Address _____ Home Phone:_____
_____ Bus. Phone: _____
In the event emergency treatment is required, I wish medical personnel to take the following action: _____ Dr.: _____ Ph:_____
Dentist: _____ Ph:_____
Emergency Contact(s):

Name:	Relationship:	Phone:
_____	_____	
_____	_____	