WCDS
P.O. Box 739, Flint Hill, Virginia 22627
(540) 635-8555 / FAX (540) 636-1501 / www.wcdsva.org

Acknowledgement of Risk and Insurance Statement

(To be completed and signed by parent/guardian)

The undersigned is the parent or guardian of *(Student Name)* _____ and is familiar with his/her wishes to participate in (*Sports)* _____ for WCDS for the 2018-2019 academic year.

I am aware that with participation in sports comes the risk of injury or even death to my child/ward. I understand that the degree of danger and the seriousness of the risk vary significantly from one sport to another, with contact sports carrying a higher risk. The above named student has accident insurance and is insured to our satisfaction. I recognize brain trauma (concussions) can occur, and I have reviewed the information for parents on the Center for Disease Control website (http://www.cdc.gov/concussion/HeadsUp/online_training.html). WCDS has recommended that I review the free online course from the National Federation of High Schools (NFHS) titled "*Concussion in Sports - What you need to Know*" on the NFHS website: www.nfhslearn.com. This is the same course WCDS coaches are required to complete.

In addition, I am aware that participation in sports will involve travel with the team. I acknowledge and accept the risks inherent in the sport and with the travel involved, and with this knowledge in mind, grant permission for my child/ward to participate in the sport and travel with the team.

I also give my consent and approval for the above named student to receive a physical examination by a qualified, registered physician, if offered through the school.

Parent/Guardian Signature: _____ Date: _____

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Name of Student (please print) _____

Grade: _____ Age: _____ Height: _____ Weight: _____

Blood Pressure: _____ Significant Past Illness or Injury: _____

Eyes: R 20/_____; L 20/_____ Hearing: R_____/15; L_____/15
Respiratory _____
Cardiovascular _____
Spleen_____ Hernia _____ Liver _____
Skin _____ Neurological _____ Genitalia _____

I certify that I have, on this date, examined this student and find him/her physically able to compete in supervised sports activities.

Date of Examination: _____ Signed: _____
Examining Physician

Physician's Address: _____

Physician's Telephone #: _____

Student's Medical History

	Yes	No
1. Has had injuries requiring medical attention?	_____	_____
2. Has had illness lasting more than one week?	_____	_____
3. Is under a physician's care now?	_____	_____
4. Takes medication now?	_____	_____
5. Wears glasses/contact lenses?	_____	_____
6. Has had surgery?	_____	_____
7. Has been a patient in a hospital?	_____	_____
8. Is there any reason why this student should not participate in all sports?	_____	_____

Please explain any "yes" answers to above questions:

Parent/Guardian Signature: _____ Date: _____