

# BENJAMIN FRANKLIN CLASSICAL CHARTER PUBLIC SCHOOL

## EXTRACURRICULAR ATHLETIC ACTIVITIES REGISTRATION FORM

In order for a student to participate in a BFCCPS extracurricular athletic activity they must submit to the following before they are cleared to participate.

- Completed Registration Form
- Completed Pre-Participation Head Injury/Concussion Reporting Form (on reverse)
- Certificate of Completion for the online course regarding head injuries (see #4 on reverse)
  - required of a parent of a participating student
  - required of a participating student in grades 6 -8
- Copy of the student's most recent physical exam dated within 13 months of the start of the activity must be on file at BFCCPS. Students who meet the criteria at the start of an activity will remain eligible for duration of that activity
- Payment of activity fee.

Student's Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Home Address: \_\_\_\_\_ Home Phone Number: \_\_\_\_\_

Mother's cell: \_\_\_\_\_ Father's cell: \_\_\_\_\_

Parent's email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Medical Insurance Carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Sport: \_\_\_\_\_ Physical Date: \_\_\_\_\_

How will the student be picked up from the activity: \_\_\_\_\_

Below for Office Use Only

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The Student above as met all the criteria for participation

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# BENJAMIN FRANKLIN CLASSICAL CHARTER PUBLIC SCHOOL

## EXTRACURRICULAR ATHLETIC ACTIVITIES PRE-PARTICIPATION HEAD INJURY/CONCUSSION REPORTING FORM

This form is to be completed by the student's parent(s) or legal guardian(s). It must be submitted to the Assistant Head of School *prior* to a student's participation in a BFCCPS athletic activity.

Name of Student : \_\_\_\_\_

Has this student ever experienced a traumatic head injury (a blow to the head)? Yes \_\_\_\_\_ No \_\_\_\_\_  
If "Yes", when? Give dates (month/year) \_\_\_\_\_

Has this student ever received medical attention for a head injury: Yes \_\_\_\_\_ No \_\_\_\_\_  
If "Yes", when? Give dates (month/year) \_\_\_\_\_  
If "Yes", please describe the circumstances: \_\_\_\_\_

Was this student diagnosed with a concussion? Yes \_\_\_\_\_ No \_\_\_\_\_  
If "Yes", when? Give dates (month/year) \_\_\_\_\_  
Duration of symptoms (ie. headache, difficulty concentrating, fatigue) for most recent concussion: \_\_\_\_\_

### I HAVE READ AND UNDERSTAND:

1. I do hereby consent to my child's participation in voluntary athletic programs and do forever release, acquit, discharge, and covenant to hold harmless BFCCPS from any and all actions, causes of action, and claims on account of, or in any way growing out of, directly or indirectly, all known or unknown personal injuries or property damage which I may now or hereafter have as a parent/guardian of said minor, and also all claims or right of action for damages which said minor has or hereafter may acquire, either before or after he/she has reached his/her majority resulting from his/her participation in the BFCCPS athletic programs.
2. I give permission for the coach to render first aid as deemed necessary.
3. I give the coach or person-in-authority my consent to seek whatever medical treatment may be necessary in the event that my son/daughter is injured or requires medical care while in his/her charge and a parent/guardian cannot be reached.
4. I have taken the online course regarding head injuries found at <http://www.cdc.gov/headsup/youthsports/training/index.htm> and submitted the Certificate of Completion (required of all parents and students grade 6-8).
5. I hereby give my permission for my son/daughter to participate in competitive athletics at BFCCPS. I understand that my child's participation in athletic programs is voluntary and that my child and I are free to choose not to participate in these programs. I also understand and agree that such activity involves the potential for minor, major or catastrophic injuries, which are inherent in all contact/non-contact sports.
6. All parents/guardians of participants ages 10 and up are encouraged to contact their primary care provider for a baseline ImPACT Test which may be used to guide return to play.

Signature of Parent/Guardian

X \_\_\_\_\_

DATE \_\_\_\_\_

Signature of Student Athlete

X \_\_\_\_\_

DATE \_\_\_\_\_