

# Crusaders Flag Football

DATE: \_\_\_\_\_ GRADE: \_\_\_\_\_

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ HOME PHONE# \_\_\_\_\_

LIVING WITH (MARK ONE): Both Parents: \_\_\_\_\_ Mother: \_\_\_\_\_ Father: \_\_\_\_\_ Guardian\* \_\_\_\_\_

MOTHER'S NAME: \_\_\_\_\_ CELL PHONE # \_\_\_\_\_

MOTHER'S EMAIL ADDRESS: \_\_\_\_\_

FATHER'S NAME: \_\_\_\_\_ CELL PHONE # \_\_\_\_\_

FATHER'S EMAIL ADDRESS: \_\_\_\_\_

(NOTE: I DO TEXT INFORMATION AND ANY PRACTICE / GAME CHANGES TO YOUR CELL. It is a quick and easy way to keep in contact & you informed of important information.)

**IN CASE OF EMERGENCY, OTHER THAN PARENT, PLEASE NOTIFY THE INDIVIDUAL BELOW:**

NAME: \_\_\_\_\_ RELATION TO ATHLETE: \_\_\_\_\_ PHONE # \_\_\_\_\_

DOCTOR: \_\_\_\_\_ PHONE # \_\_\_\_\_ ADDRESS: \_\_\_\_\_

PHYSICAL HANDICAPPS (If any): \_\_\_\_\_ GENERAL HEALTH: \_\_\_\_\_

ALLERGIES (If any): \_\_\_\_\_ SYMPTOMS: \_\_\_\_\_

DOES THE ATHLETE RECEIVE MEDICATION? \_\_\_\_\_ TYPE OF MEDICATION? \_\_\_\_\_

TIME GIVEN? \_\_\_\_\_ REASON FOR MEDICATION? \_\_\_\_\_

ANY HEALTH CONCERNS WE SHOULD BE AWARE OF? \_\_\_\_\_

WHO IS AUTHORIZED TO PICK UP YOUR ATHLETE FROM PRACTICE OR A GAME? If someone other than the above indicated parent(s) is picking up your athlete, PLEASE text us, Coach Ted (904-219-2085) or Coach Eugene (904-554-8536) to inform us of whom. Person picking up your athlete must have ID. (PLEASE PROVIDE FIRST AND LAST NAME) \_\_\_\_\_

**PLEASE CIRCLE ALL MEDICATIONS THAT APPLY**

I give my permission for my child-athlete to be given the following over the counter medications by the athletic staff of CHA—**IBUPROFEN / NAPROXEN / ACETAMINOPHEN** during practice and/or at a game if needed. Specify the dosage / number of pills you typically give your child \_\_\_\_\_