AVIANO SAINTS SPORTS

PLEASE SIGN AND RETURN THE FOLLOWING PAGE TO YOUR COACH. A COPY MUST BE ON FILE WITH THE ATHLETIC DIRECTOR IN ORDER FOR YOU TO PARTICIPATE IN AVIANO ATHLETICS.

Parent/Sponsor Printed Name: _____ Date: _____

Player/Student Printed Name: _____ Grade:_____

I have read and understand the DODDS Europe eligibility policy.

Sponsor Signature:_____ Student Signature: _____

I have read and understand the DODDS Europe Drug & Alcohol policy. I will honor these expectations for the duration of the season.

Sponsor Signature:_____ Student Signature: _____

I have read and understand the Student Behavior Expectations. I will honor these expectations for the duration of the season.

Sponsor Signature:_____ Student Signature:_____

I have read and understand the lettering criteria and understand that failure to fulfill these requirements means that I will not receive a letter at the end of the season banquet.

Sponsor Signature: _____ Student Signature: _____

I have read and understand the risk of concussion associated with athletic participation.

Sponsor Signature: _____ Student Signature: _____

I have read and understand that I need to act as a positive and respectful member of the Aviano Middle/High School family and community. I will always remember the words of Mr. Alan Parkinson, "If you think it's wrong, it probably is, so don't do it."

Student Signature: _____

I give my student permission to engage in intramurals, extracurricular activities, and interscholastic athletics, and to travel as a team member to all away scheduled competitions, events, and activities.

Sponsor Signature: _____

AVIANO MIDDLE/HIGH SCHOOL ATHLETIC/

EXTRA-CURRICULAR INFORMATION SHEET

Sport/Activity/Club_____

Last Name: _____First Name:_____

Italian city:_____Date of Birth:_____

Sponsor's Name: _____

Home Phone:_____Sponsor's Wk Phone:_____

Sponsor's Cell No:_____Student's Cell No:_____

Player's Email Address: _____

Sponsor's Email Address:_____

Grade: Returning Letterwinner? Yes No

High School Experience: Youth Experience:

Seminar Teacher_____Locker Number_____

ID#_____Passport #_____

Nationality_____Hometown_____

Class Schedule

_____ _____

_____ _____

_____ _____

_____ _____

MEDICAL RELEASE FORM-ATHLETICS

Please print legibly

DATE_____

_____ _____
STUDENT NAME: (Last) (First) (MI) STUDENT PASSPORT NUMBER/COUNTRY OF ORIGIN

_____ _____
PARENT/SPONSOR (Rank) (Last Name) (First) ADDRESS(CMR/PSC)

_____ _____
LOCAL HOME ADDRESS (Civilian with local city code) APO/FPO

_____ _____
***HOME TEL. NO. (Include country and city prefixes)** DSN TEL. NO.

EMAIL CONTACT: _____

Additional Contact Name (other than your own)_____

Additional Contact Telephone (Include country and city prefixes)_____ _____

Health Insurance Company

Policy #_____ Health Insurance Company Telephone # _____

Insurance Company Address_____

(Circle One) Civilian Insurance Co Military Insurance

==========

In the event that my dependent,_____, age_____, is injured or becomes ill, necessitating immediate medical examination or care, while participating in the _____ I authorize and release supervising personnel of the activity to take my dependent to any U.S. Medical facility or to any civilian hospital if deemed necessary.

I understand that the above supervising personnel of this activity will use all diligent and responsible efforts to contact me or my spouse. If neither my spouse nor I can be contacted after reasonable attempts by these personnel, or the U.S. medical treatment facility, I authorize and release any physician or other qualified medical personnel to examine my child. I authorize any and all emergency care necessary for treating injuries or illness involving immediate danger to life or limb of my dependent. I further authorize and release any physician or other qualified medical personnel to administer non-emergency care necessary to treat minor injuries or illness of my dependent. I authorize necessary treatment such as suturing superficial lacerations, treating colds, minor allergies and minor gastrointestinal upsets, splinting sprains, casting uncomplicated fractures, or other similar treatment, not including major surgery or procedures involving substantial risk.

My dependent is allergic to: _____

My dependent requires the following medication: _____

Additional Comments: _____

X_____ _____
PARENT/SPONSOR SIGNATURE SOCIAL SECURITY NUMBER (Last 4 only)

THIS FORM DOES NOT HAVE TO BE NOTARIZED