Kansas City Lutheran Athletic League
Roster From

Student Name____ Date_____________

Address ____ Grade__________
(include city, state and zip)
Parent's or Guardian's Name(s):____

Home Phone______________________ Email _____________________________________

Mom Cell#_______________________ Dad Cell#_____________________________

Mom's Work Phone_______________ Dad's Work Phone_____________________

Name of Student's Physician_______________________________________
Address_________________________Phone__________________________
Hospital Preference_______________________________________
Is your physician listed above permitted to practice in this hospital? Yes____ No_____

PARENT/GUARDIAN PERMISSION

I hereby give consent for the above student to represent his/her school in interscholastic activities. I give my consent for him/her to accompany the team on its out-of-town trips and will not hold the school responsible in case of an accident or injury. In the event of an emergency, an effort will be made to contact a parent or guardian. If this is not possible, I also give my consent and authorize the school to obtain, through a physician of its own choice, such medical care as is reasonably necessary for the welfare of the student, including first aid treatment, hospitalization, injections, anesthesia or surgery. I also will assume responsibility for all medical expenses not covered by our insurance.

____________________________________ __________________________
Parent/Guardian Signature Date

The Kansas City Lutheran Athletic League strongly recommends that every student be covered by insurance. Please provide the following information:

Insurance Company___________________________Policy Number________________
Phone No. __________________________________Group Number ________________

<u>If you do not have insurance, you must sign the following waiver:</u>

I acknowledge that I do not have adequate health insurance to cover injuries to my child and will assume financial responsibility for all medical expenses if an injury should occur as a result of school athletics. I will not hold KCLAL, my child's school, its administration and employed teachers and officials (employed by the KCLAL and/or my child's school) responsible for the injury.

________________________________ __________________________
Parent or Guardian Signature Date
(sign only if you do not have insurance)

REQUIRED
Kansas City Lutheran Athletic League
Physical Examination Record

______________________________________ ______________________

Name of Student (Please print) Date of Birth

Significant past illnesses or injuries:____

Eyes, ears, nose, throat_____________

Lungs__________________________

Abdomen________________________

Genitalia________________________

Muscular-skeletal_________________

Reflexes_________________________

Urinalysis_______________________

Hernia__________________________

Heart___________________________

Resting Heart Rate__________

Blood Pressure____________

Height___________________

Weight___________________

Date of last immunization:

Polio____________________

Tetanus__________________

Other____________________

Blood count or x-ray (only if indicated) to filed in school office.

I certify that I have examined the above student. I have noted any participation restrictions on the lines below.

Basketball______________________

Cheerleading____________________

Soccer__________________________

Track____________________

Volleyball_________________

Other____________________

_____________________________ _______________________

Date of Examination Examining Physician