St. Paul Lutheran School Registration Payment Agreement - 2023-2024

Parent Name(s) ______________________ Date ______________

Billing Address ____

Father SS Number ______________ Mother SS Number ______________

Cell Phone Number ______________ Cell Phone Number ______________

Email Address ______________ Email Address ______________

Church Affilitation ______________________________

Preschool Tuition*

		NAME	BIRTHDATE	AMOUNT
☐	PS 3 AM - $750			
☐	PS3 PM - $750			
☐	PS4 AM - $1,100			
☐	PS4 PM - $1,100			
☐	PS Full Day - $1,700			
☐	Registration - $75			
	(Registration Fee Non-Refundable)		***Preschool Subtotal***	

K-8 Tuition*

		NAME	GRADE	BIRTHDATE	AMOUNT
☐	Member - $1,422				
☐	Child #2 - $1,137				
☐	Child #3 - $829				
☐	Child #4 - $829				
☐	Non-Member - $2,841				
☐	Child #2 - $2,558				
☐	Child #3 - $2,273				
☐	Child #4 - $2,273				
				K-8 Tuition Subtotal	

K-8 Fees *(non-refundable)*

		AMOUNT
☐	Registration - $300	
☐	Technology Fee - $100	
☐	Assembly Fee - $10	
☐	Payment Plan Fee - $60	
☐	Scholastic News (Kdg) - $9	
☐	Scholastic News (Grades 1-2) - $8	
☐	Band Book (Grades 5-6) - $10	
☐	Catechism (Grades 7-8) - $20	
☐	Athletic Fee - $50	
	Fees Subtotal	

Fees are assessed per each student enrolled.

Notes and/or Comments:

TOTAL	
(-) Gifts	
(-) Payments	
GRAND TOTAL (balance due)	

** Tuition is pro-rated if child is withdrawn.*

Payment Plans *(initial preferred option)*

☐ **Option 1:** Pay in full via any payment method.

☐ **Option 2:** Pay over 10 months (August through May) - ACH or credit card on file.

* Requires monthly installments of $ __________ per month.
* We will charge your credit card or debit ACH bank draft on the 10th of each month regardless if the 10th falls on a weekend or holiday.
* Late fees of 3% or bank fee of $25 apply if credit card is declined or bank returns check.

Certification *(initial each box)*

☐ I understand and agree that I am responsible for all tuition and fees assessed per this schedule as indicated above.

☐ I understand and agree that I am responsible for all fees incurred due to declined credit cards or checks returned from the bank. Minimum charge is $25.

☐ I understand and agree that I am responsible for additional fees should this account go to collections due to non-payment of account.

~Notice~
Accounts are forwarded to the collection agency on May 11, 2024 (Option 2) if not paid in full.
Accounts in PRIOR Collections MUST use Option 1 upon registration

______________________________	______________________________
Parent or Guardian - *Signature*	Parent or Guardian - *Signature*
______________________________	______________________________
Parent or Guardian - *Printed*	Parent or Guardian - *Printed*

EMERGENCY/HEALTH INFORMATION

CHILD'S LAST NAME ______________________________ DATE ____________

CHILD *(first name)* ______________________________ GRADE ________

CHILD *(first name)* ______________________________ GRADE ________

CHILD *(first name)* ______________________________ GRADE ________

MOM'S FIRST NAME ________________ LAST NAME *(if different)* ________________

CELLL PHONE ________________ WORK PHONE ________________

DAD'S FIRST NAME ________________ LAST NAME *(if different)* ________________

CELL PHONE ________________ WORK PHONE ________________

Parents' (guardians), cell and work will be contacted first. In an emergency, contact the following if the parents/guardians are unavailable. List in order of desired contact.

1. ______________________________ PHONE ________________

   RELATIONSHIP TO CHILD ____________________

2. ______________________________ PHONE ________________

   RELATIONSHIP TO CHILD ____________________

DAYCARE ______________________________ PHONE ________________

HEALTH INSURANCE COMPANY ______________________________

(Please attach a copy of health insurance card)

EMPLOYER PROVIDING ________________ HOSPITAL PREFERENCE ________________

FAMILY DOCTOR ________________ PHONE NUMBER ________________

HEALTH/ALERGY INFORMATION

Please provide the following information where applicable.

CHILD'S NAME	DIETARY RESTRICTION(S)	ALERGY INFORMATION	OTHER

I agree that school personnel may authorize emergency medical treatment for the above named child(ren).

______________________________ ________________

(Parent Signature) *Date*

Auxiliary Registration Form

St. Paul Lutheran School

Please take note and/or complete the forms below that pertain to your child(ren).

CHRISTMAS PROGRAM DATE - FOR ALL STUDENTS 2023-2024

There will only be one **Children's Christmas Service** on **Sunday, December 17**, at **4:00 p.m.** We would urge that all students attend if at all possible. Please indicate below whether your child(ren) will be in attendance, and if so, their name(s)/grade(s).

☐ My child(ren) will be able to attend.
☐ My child(ren) willl not be able to attend.

Student Names	Grade
______________________	______
______________________	______
______________________	______
______________________	______

TRANSPORTATION INFO - FOR STUDENTS NEEDING TO RIDE THE BUS

If your child(ren) is in need of bus transportation to and from St. Paul, a special form must be completed for the Millington Bus Garage indicating student pick-up and drop-off locations. A **Millington Bus Form** can be accessed online or picked up in the School Office.

ATHLETICS - FOR STUDENTS PARTICIPATING IN ANY SPORT

St. Paul is a member of the Tri-County Lutheran League (TCLL). The school competes with fellow Christian schools and occasionally with neighboring public schools. The grades eligible to participate in interscholastic competition will vary from year-to-year and sport-to-sport depending upon class sizes. School policy requires that a health examination be submitted prior to participation (and prior to any practice). A **Physical Exam and Clearance and Consent Form** can be accessed online or picked up in the School Office.

BAND - FOR STUDENTS PARTICIPATING IN BAND - GRADES 5-8

St. Paul offers Band to students in Grades 5-8, with Band being a requirement for Grade 5. (Instruments are provided for fifth graders.) All students must complete a form providing any history of musical experience and/or choice of instrument. A **Band Enrollment Form** can be accessed online or picked up in the School Office.

FIELD TRIP INFORMATION

From time to time, all grades at St. Paul, go on field trips. Parents are normally notified by your child(ren)'s teacher along with a request for either parent chaperones or drivers. If you are able to help out, that is most appreciated; however, by law the school is required to have parents complete an ICHAT Information Sheet one week prior to the event. In conjunction with this form, a copy of the parent's driver's license is required as well. An **ICHAT Information Sheet** can be accessed online or picked up in the School Office. If you choose to come into the office, they would be happy to make a copy of your driver's license for you.

VOLUNTEERS

Each classroom has a number of volunteer needs throughout the school year. If you are interested and/or have the opportunity to serve, please complete a **Volunteer Information Form** in the School Office.

TECHNOLOGY ACCEPTABLE USE POLICY

Student Technology Code of Ethics and Rules for Computer/Laptop/iPad Use

1. I will respect and care for the integrity of computing systems and all other technological devices.
2. I will respect the privacy of other users.
3. I will only modify, delete, or change files that I have created myself.
4. I will only use my personal logins and passwords and keep them private.
5. I will only use school-installed software, apps, extensions, etc., unless given express permission from the instructor.
6. I will only make copies of software or files from school computers of networks in which I have been given permission.
7. I understand and respect the copyright laws as well as other's intellectual property.
8. I will only alter computer settings with teacher consent.
9. Laptops are not to leave the school building and will only leave the classroom at the teacher's direction. Students are not to use another student's laptop without permission from the teacher.
10. When not in use, laptops will be kept in the charging cart in the classroom. The student is responsible for returning the computer to the charging cart at the end of the day to make sure that it is charged for the following day. Students will only remove laptops from the charging cart with the teacher's permission.
11. **Laptops are school property, and will remain so until the student graduates from St. Paul in the eighth grade. It is the student's responsibility to report problems or malfunctions to the instructor as soon as they occur. If a laptop breaks, the student will be temporarily given an extra computer to use while theirs is repaired. If it is shown that the laptop is broken due to the student's negligent behavior, the student/parent can be held responsible for the cost of any repairs, up to the cost of replacing the computer.**

Internet User Agreement

Internet access is available to all students at St. Paul Lutheran School. We are committed to providing excellence in our school by facilitating resource-sharing, communication, and access to current information; however, it is a privilege not a right! This internet user agreement applies to all devices used in our building, including computers, tablets, and personal phones.

With the ability to access information from all over the world also comes the availability of information that may not be considered of educational value. Although we try to keep students safe, it is impossible to control all materials that an industrious user may find. Student first names and last initials are used only on secure, password-protected sites created by the teacher. Students are not to post private information online. We believe having access to research, information, communications, and other educational materials electronically supports the goal of educational excellence.

The following are examples of, but not limited to, inappropriate use of the Internet and are in violation of school policy:

**** Use of technology or networks in an illegal or unethical manner**
**** Use of profanity** ****Plagiarism** ****Accessing pornographic material**
**** Use of another person's access or email address** ****Accessing/downloading games not directed by teacher**
****Accessing/posting on social media sites including Facebook, Instagram, Snapchat, etc.**

I have read both the St. Paul Lutheran School **Student Technology Code of Ethics and Rules for Computer/Laptop/iPad Use** and the **Internet User Agreement.** I understand that the above policy applies to on- or off-site usage of equipment and that violating these regulations may result in the loss of using St. Paul Lutheran School's technology and that disciplinary action may be taken.

Student Name ____ Date: ______________________
Signature of Student

I (We), the undersigned parent(s)/legal guardian of ______________________________, have read and thoroughly discussed with my (our) son/daughter the school's **Student Technology Code of Ethics and Rules for Computer/Laptop/iPad Use** and the **Internet User Agreement**, and hereby agrees to the conditions, rules, and regulations. By signing this form, I (We) agree to be responsible for my (our) son/daughter's compliance with said **Technology Acceptable Use Policy** as indicated above. I (We) assume all responsibility for any liability associated with his/her use of the Internet. I (We) further understand and agree that the school assumes no responsibility for his/her inappropriate use of communications while using the Internet.

I (We) understand that violation of the **Student Technology Code of Ethics and Rules for Computer/Laptop/iPad Use** and/or the **Internet User Agreement** is considered serious by St. Paul Lutheran School. Disciplinary action may be imposed up to and including suspension and/or expulsion, financial restitution, and/or a ban from using school technology equipment.

____ Date: ______________________________
Signature of Parent(s)/Legal Guardian

CHILD PICK- UP AUTHORIZATION FORM

Child's Name: _________________________Grade:________

Person authorized to pick up my child this school year:

____

____

____

Person who may NOT pick up my child:

____

____

Signature: ____

Relationship: ____

Date: ___________

Please contact the school office if someone other than the people listed above, will be picking up your child. **Initial of parent or guardian:** _____

MILLINGTON BUS
PICK UP AND DROP OFF LOCATION

STUDENT INFORMATION

Date Form Completed: ____

School Building: ____________________________________Grade__________

Student's Name: ____

Parent's Name (s):____

Address: ____

Phone Number: ____

PICK UP & DROP OFF SITE

Name of Adult Responsible:_______________________________________

Address: ____

Crossroads: ____

Phone Number: ____

EMERGENCY PHONE NUMBER

Phone Number: ____

Please return this form to the principal of the school your child attends. If you have children in more than one school, a form will need to be made out for each individual child and sent to the principal involved.

St. Paul Lutheran School

STUDENTS IN GRADES 5-8

Name:___________________________Date:_____________________________

Age:_________ Grade:_______

Beginning this Year: Circle one Yes No

Years of Experience in Band_____________

Instrument: First Choice_________________________

Second Choice_______________________

This information expires on June 30, _____.

SCHOOL-BASED ASTHMA MANAGEMENT PLAN

Endorsed by the Michigan Asthma Steering Committee of the Michigan Department of Community Health

STUDENT INFORMATION

Child's Name: ____ Birth Date: ___________

Grade:__________ Home Room Teacher: ____

Physical Education Days and Times: ____

EMERGENCY INFORMATION

TO BE COMPLETED BY THE CHILD'S PARENT/GUARDIAN:

Parent/Guardian Name(s): ____

____

First Priority Contact: Name ____

Phone ____

Second Priority Contact: Name ____

Phone ____

Doctor's Name: ______________________________ Phone: ________________

TO BE COMPLETED BY THE CHILD'S DOCTOR:

WHAT TO DO IN AN ACUTE ASTHMA EPISODE:
1.
2.
3.

CALL 911 OR AN AMBULANCE IF: Review attached "Signs of an Asthma Emergency" and list any additional symptoms the child may present with:

DAILY MANAGEMENT PLAN - **TO BE COMPLETED BY THE CHILD'S DOCTOR.**

OVER FOR DAILY MANAGEMENT PLAN

Child's Name: ___________________

Be aware of the following asthma triggers: ____

____

Severe Allergies: ____

MEDICATIONS TO BE GIVEN AT SCHOOL:

NAME OF MEDICINE	DOSAGE	WHEN TO USE

Side effects to be reported to health care provider: ______________________________

____

Does this child have exercise-induced asthma? **Yes No**

G This child uses an inhaler before engaging in physical exercise and if wheezing during physical activity.

Activity Restrictions (e.g., staying indoors for recess, limited activity during physical education):

____

____

Please check all that apply:

G I have instructed this child in the proper way to use his/her inhaled medications. It is my professional opinion that this child **should be allowed to carry and use** that medication by him/herself.

G It is my professional opinion that this child **should not** carry his/her inhaled medications or epi-pen by him/herself.

G Please contact my office for instructions in the use of this nebulizer, metered-dose inhaler, and/or epi-pen.

G I have instructed this child in the proper use of a peak flow meter. His/her personal best peak flow is:_______.

Doctor's Signature:________________________________ Date: _________

Parent/Guardian's Signature(s): ________________________ Date: _________

________________________ Date: _________

Medical Statement for Student ***With*** a Disability

Requires Special Foods in Child Nutrition Programs

Student's Name: ______________________________ Age: ______ Grade: ______

Name of parent/guardian: ______________________________ Phone #: ______________

Name of disability: ______________________________

Explanation of why disability restricts child's diet: ______________________________

____

Major life activity affected by disability: ______________________________

Foods to Omit:

____

____

____

____

____

____

Foods to Substitute:

____

____

____

____

____

____

Other information regarding diet or feeding: (provide additional information below or on back of form or attach to this form).

____

____

____

I certify that the above named student needs special school meals prepared as described above because of the student's disability or chronic medical condition.

____

Physician's Signature

Office Phone Number: ______________________ Date: ______________________

In accordance with Federal law and U. S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

eCheck Authorization Form

St Paul Evangelical Lutheran Congregation, Millington, Michigan

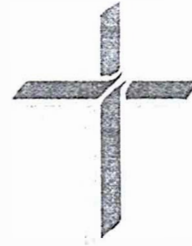
I authorize St Paul Evangelical Lutheran Congregation (aka St Paul Lutheran Church and School) to initiate either an electronic debit or to create and process a demand draft against my bank account according to the terms outlined below. I acknowledge that the origination of ACH transactions to my account must comply with the provisioning of United States law.

Terms of Billing

Option 1 – Pay in full for the amount of ________________.

Option 2 - Starting on ________________ and on the 10th day of each month through May 2023 in the amount of ________________.

Bank Information



Routing Number: ________________________________

Account Number: ________________________________

Account Type: __ Checking __ Savings

This payment authorization is to remain in full force and effect until I, ________________________, notify St Paul Lutheran Church & School of its cancellation by sending written notice in such time and in such manner to allow both St Paul Lutheran Church & School and the receiving financial institution a reasonable opportunity to act on it.

I further acknowledge in the event of non-sufficient funds (NSF), I will be liable for resulting NSF fees and billed appropriately.

Member Signature: ________________________________

Member Printed Name: ________________________________

Date: ________________________________

Note: once information is entered into your electronic PCI-Compliant account, this form is destroyed. Account information is truncated within your account and cannot be read by anyone within our church or school.

Credit Card Authorization Form St Paul Evangelical Lutheran Congregation, Millington, Michigan

I authorize St Paul Evangelical Lutheran Congregation (aka St Paul Lutheran Church and School) to initiate either an electronic debit or to create and process a demand draft against my credit card account according to the terms outlined below. I acknowledge that the origination of credit transactions to my account must comply with the provisioning of United States law.

Terms of Billing

Option 1 – Pay in full for the amount of ________________.

Option 2 - Starting on ________________ and on the 10th day of each month through May 2023 in the amount of ________________.

Credit Card Information (**Credit** cards only – no debit cards)

Card Number: ________________________________

Exp Date: ________________________________

CVC code: __________ Billing zip code: ____________

This payment authorization is to remain in full force and effect until I, ________________________, notify St Paul Lutheran Church & School of its cancellation by sending written notice in such time and in such manner to allow both St Paul Lutheran Church & School and the receiving financial institution a reasonable opportunity to act on it.

I further acknowledge in the event of credit card declination, I will be liable for resulting declination fees and billed appropriately.

Member Signature: ________________________________

Member Printed Name: ________________________________

Date: ________________________________

Note: once information is entered into your electronic PCI-Compliant account, this form is destroyed. Account information

MEDICAL HISTORY: Completed by Parent or Guardian or 18 Year Old

Student Name: ______________________ Date of Birth: __________

Doctor: ______________________ Doctor's Phone: __________ Date of Exam: __________

GENERAL QUESTIONS	Y	N
Has a doctor ever denied or restricted your participation in sports for any reason?		
Do you have any ongoing medical conditions? If so, please identify below:		
❑ Asthma ❑ Anemia ❑ Diabetes ❑ Infections ❑ Other:		
Have you ever spent the night in the hospital or have you ever had surgery?		
Do you have any concerns that you would like to discuss with a doctor?		
HEART HEALTH QUESTIONS ABOUT YOU	**Y**	**N**
Have you ever passed out or nearly passed out DURING or AFTER exercise?		
Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
Has a doctor ever told you that you have any heart problems? Check all that apply:		
❑ High blood pressure ❑ Heart murmur ❑ Heart infection ❑ High cholesterol		
❑ Kawasaki disease ❑ Other:		
Has a doctor ordered a test for your heart? (example, ECG/EKG, echocardiogram)		
Do you get lightheaded or feel more short of breath than expected during exercise?		
Do you have a history of seizure disorder or had an unexplained seizure? Fainting?		
Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Y**	**N**
Has anyone in your family had a pacemaker or implanted defibrillator before age 35?		
Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic, right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
BONE AND JOINT QUESTIONS	**Y**	**N**
Have you ever had an injury to a bone, muscle, ligament or tendon that caused you to miss a practice or a game?		
Have you ever had any broken or fractured bones, dislocated joints or stress fracture?		
Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast or crutches?		
Do you regularly use a brace, orthotics or other assistive device?		
Do you have a bone, muscle or joint injury that bothers you?		
Do any of your joints become painful, swollen, feel warm or look red?		
Do you have any history of juvenile arthritis or connective tissue disease?		
Have you ever had an x-ray for neck instability or atlantoaxial instability (Down syndrome or dwarfism)?		

MEDICAL QUESTIONS	Y	N
Do you cough, wheeze or have difficulty breathing during or after exercise?		
Have you ever used an inhaler or taken asthma medicine?		
Is there anyone in your family who has asthma?		
Were you born without, or missing a kidney, eye, testicle (males), spleen or any other organ?		
Do you have groin pain or a painful bulge or hernia in the groin area?		
Have you had infectious mononucleosis (mono) within the last month?		
Do you have any rashes, pressure sores or other skin problems?		
Have you had a herpes or MRSA skin infection?		
Do you have headaches or get frequent muscle cramps when exercising?		
Have you ever become ill while exercising in the heat?		
Do you or someone in your family have sickle cell trait or disease?		
Have you had any problems with your eyes or vision or any eye injuries?		
Do you wear glasses or contact lenses?		
Do you wear protective eyewear such as goggles or a face shield?		
Immunization History: Are you missing any recommended vaccines?		
Do you have any allergies?		
Have you ever had a head injury or concussion?		
Have you ever received a blow to the head that caused confusion, prolonged headache or memory problems?		
Have you ever had numbness, tingling, weakness or inability to move your arms or legs after being hit or falling?		
Have you ever had an eating disorder?		
Do you worry about your weight?		
Are you trying to or has anyone recommended that you gain or lose weight?		
Are you on a special diet or do you avoid certain types of foods?		
FEMALES ONLY (Optional)	**Y**	**N**
Have you ever had a menstrual period?		
If "YES", When was your most recent menstrual period?		
How old were you when you had your first menstrual period?		
How many periods have you had in the last 12 months?		

CURRENT-YEAR PHYSICAL = GIVEN ON OR AFTER APRIL 15 OF THE PREVIOUS SCHOOL YEAR

Please explain any "YES" answers: ______________________

PHYSICAL EXAMINATION & MEDICAL CLEARANCE: Completed by MD, DO, PA or NP - RETURN DIRECTLY TO PATIENT

EXAMINATION: Height: Weight: ❑ Male ❑ Female BP: / Pulse: Vision: R 20/ L 20/ Corrected: ❑ Y ❑ N

MEDICAL	NORMAL	ABNORMAL	MUSCULOSKELETAL	NORMAL	ABNORMAL
Appearance: Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)			Neck		
Eyes/Ears/Nose/Throat Pupils Equal Hearing			Back		
Lymph nodes			Shoulder/Arm		
Heart: Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (PMI)			Elbow/Forearm		
Pulses: Simultaneous femoral and radial pulses			Wrist/Hand/Fingers		
Lungs			Hip/Thigh		
Abdomen			Knee		
Genitourinary (males only)			Leg/Ankle		
Skin: HSV: Lesions suggestive of MRSA, tinea corporis			Foot/Toes		
Neurologic			Functional Duck Walk		

RECOMMENDATIONS: ______________________

I certify that I have examined the above student and recommend him/her as being able to compete in supervised athletic activities except: __________

Name of Examiner (print/type): ______________________ Date: __________

Signature of Examiner: ______________________ (Check One): ❑ MD ❑ DO ❑ PA ❑ NP

(DETACH HERE IF NEEDED TO ACCOMPANY STUDENT-ATHLETE)

EMERGENCY INFORMATION: COMPLETED BY PARENT or GUARDIAN or 18 YEAR OLD

Student: __________ Grade: ____ Doctor: __________ Phone: (____)________

IN EMERGENCY (1): __________ Home #: (____)________ Cell #: (____)________

IN EMERGENCY (2): __________ Home #: (____)________ Cell #: (____)________

Drug Reactions: __________ Current Medications: __________

Allergies: ______________________

PRE-PARTICIPATION PHYSICAL - CONSENT - INSURANCE

Shaded headline areas are to be completed by student, parent/guardian or 18-year-old

There are **FOUR** (4) signatures on this page (4) to be completed by student, parent/guardian and/or 18-year-old

A CURRENT-YEAR PHYSICAL IS ONE GIVEN ON OR AFTER APRIL 15 OF THE PREVIOUS SCHOOL YEAR

Student Name: ____
LAST FIRST MIDDLE INITIAL

Student Address: ____
STREET CITY ZIP

Sex: ❑ M ❑ F Age: _______ Date of Birth: _______________ Place of Birth (City/State): ______________________

School: ______________________________________ Circle Grade: 6 7 8 9 10 11 12

Parent/Guardian Name: ____

Phone (home): ______________________ (work): ______________________ (cell): ______________________

Parent/Guardian Name: ____

Phone (home): ______________________ (work): ______________________ (cell): ______________________

Email Address: Parent/Guardian/18-Year-Old: ____

STUDENT PARTICIPATION & PARENT or GUARDIAN or 18-YEAR-OLD CONSENT

The information submitted herein is truthful to the best of my knowledge. By my/my child's signature below, **I/we acknowledge that I/we have received concussion educational information that meets Michigan Department of Health and Human Services and MHSAA requirements.**

Further, in consideration of my/my child's participation in MHSAA-sponsored athletics, I/we do hereby agree, understand, appreciate, and acknowledge: **that participation in such athletics is purely voluntary; that such activities involve physical exertion and contact and that there is inherent risk of personal injury associated with participation in such activities, which risk I/we assume;** and that I/we agree to, and hereby waive any and all claims, suits, losses, actions, or causes of action against the MHSAA, its members, officers, representatives, committee members, employees, agents, attorneys, insurers, volunteers, and affiliates based on any injury to me, my child, or any person, whether because of inherent risk, accident, negligence, or otherwise, during or arising in any way from my/my child's participation in an MHSAA-sponsored sport.

I/we understand that I am/we are expected to adhere firmly to all established athletic policies of my school district and the MHSAA. I/we hereby give my consent for the above student to engage in interscholastic athletics and for the disclosure to the MHSAA of information otherwise protected by FERPA and HIPAA for the purpose of determining eligibility for interscholastic athletics. My child has my permission to accompany the team as a member on its out-of-town trips.

(1) Signature of **STUDENT**: ______________________________________ Date: ______________

(2) Signature of **PARENT** or **GUARDIAN** or **18-YEAR-OLD**: ______________________________ Date: ______________

INSURANCE STATEMENT

Our son/daughter will comply with the specific insurance regulations of the school district.

The student-athlete has health insurance: ❑ YES ❑ NO

If YES, Family Insurance Co: ______________________ Insurance ID #: ______________________

Additionally, I hereby state that, to the best of my knowledge, my answers to the medical history questions (see reverse) are complete and correct.

(3) Signature of **PARENT** or **GUARDIAN** or **18-YEAR-OLD**: ______________________________ Date: ______________

(DETACH HERE IF NEEDED TO ACCOMPANY STUDENT-ATHLETE)

MEDICAL TREATMENT CONSENT: COMPLETED BY PARENT or GUARDIAN or 18-YEAR-OLD

I, ______________________________, an 18-year-old, or the parent or guardian of ______________________________, recognize that as a result of athletic participation, medical treatment on an emergency basis may be necessary, and further recognize that school personnel may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the then-existing circumstances and to assume the expenses of such care.

(4) Signature of **PARENT** or **GUARDIAN** or **18-YEAR-OLD**: ______________________________ Date: ______________