

Charlotte-Mecklenburg Schools
Middle School Student-Athlete Pre-Participation Form
TAB THROUGH FORM & TYPE INFORMATION OR PRINT FORM AND WRITE INFORMATION

PERSONAL & EMERGENCY CONTACT INFORMATION

Student-Athlete's Name (First, MI, Last): _____ **CMS Student ID #** _____

Gender: M F **Date of Birth:** _____ **Age:** _____ **Home Phone:** _____

Resides At Street Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____ **County:** _____

Father's Name: _____ **Daytime Phone:** _____ **Cell Phone:** _____

Street Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____ **County:** _____

Mother's Name: _____ **Daytime Phone:** _____ **Cell Phone:** _____

Street Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____ **County:** _____

If applicable... **Guardian's Name:** _____ **Daytime Phone:** _____ **Cell Phone:** _____

Street Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____ **County:** _____

• If student-athlete resides with other than parent(s), attach legal documentation of custody (guardianship or affidavit provided by Student Placement)

Failure to provide accurate and up-to-date residence information may be grounds for loss of athletic eligibility

SPORT (check all sports you are considering to participate in)

<input type="checkbox"/> Cheerleading	<input type="checkbox"/> Basketball - Boy's	<input type="checkbox"/> Baseball
<input type="checkbox"/> Football	<input type="checkbox"/> Basketball - Girl's	<input type="checkbox"/> Soccer - Boy's
<input type="checkbox"/> Golf - Boy's	<input type="checkbox"/> Cheerleading	<input type="checkbox"/> Soccer - Girl's
<input type="checkbox"/> Golf - Girl's		<input type="checkbox"/> Track - Boy's
<input type="checkbox"/> Softball		<input type="checkbox"/> Track - Girl's
<input type="checkbox"/> Volleyball - Girl's		

INSURANCE

School Board Policy JLA requires that all students who participate in athletics be adequately covered by medical or accident insurance. We acknowledge that it is the signed responsibility to notify CMS of any changes that occur to the personal insurance policy below and affect the procedures in which the above-named individual may receive treatment; this includes loss of coverage. We certify that we have purchased and will maintain in full force and effect during student-athlete's participation in athletics the following insurance policy:

Check One: School Accident Insurance Personal Insurance Company

Name of Insurance Company _____ **Policy Number** _____ **Group Number** _____

Insurance Phone for Authorization _____ **Policy Holder** _____

RELEASE

In consideration of CMS allowing the above-named individual to participate in athletics, we agree to release and hold CMS, its athletic coaches, and other employees free, harmless and indemnified from and against any and all claims, suits, or causes of action arising from or out of injury that the student-athlete may suffer from participation in athletics other than an injury from gross or willful negligence.

ASSUMPTION OF RISK

We acknowledge and understand that there is a risk of injury involved in athletic participation. We understand that the student-athlete will be under the supervision and the instructions of the coach in order to reduce the risk of injury to the student-athlete and other athletes. However, we acknowledge and understand that neither the coach nor CMS can eliminate the risk of injury in sports. Injuries may and do occur. *Sports injuries can be severe and in some cases may result in permanent disability or even death.* We freely, knowingly, and willfully accept and assume the risk of injury that might occur from participation in athletics.

HIPAA / FERPA RELEASE

The above named student-athlete has opted his/her rights under the US Department of Health and Human Resources guidelines. By signing this release, the student-athlete allows sharing of medical information between the Sports Medicine Staff (team physicians and medical staff, athletic trainers, and student assistants), the CMS Athletics Staff (Athletic Director and Coaches), CMS Administration and his/her medical provider(s). In the event of an emergency situation, information may be shared with emergency medical personnel. Every reasonable effort will be made to protect this information. It is understood that once this medical information is disclosed, it is no longer protected under the HIPAA/FERPA guidelines.

SEVENTH GRADE ENTRY

• _____ is my _____ consecutive semester at _____ Middle School

• I initially entered the seventh grade in the fall of (yr.) _____

• Last semester I attended _____ School in City _____ State _____

Parent/Guardian Initials: _____ **Student-Athlete Initials:** _____

MEDICAL HISTORY

** Please take the time, read through the questions, and answer to the best of your knowledge.**

The following questions should be answered by the student-athlete with the assistance of a parent/guardian. Explain any "Yes" answers below. If additional space is needed, please attach to this form.

General Medical History

YES NO

1. Does the athlete have a chronic illness or see a doctor regularly for any particular problem? YES NO
2. Has the athlete had surgery other than a tonsillectomy? YES NO
3. Has the athlete ever been hospitalized? YES NO
4. Does the athlete have sickle cell trait? YES NO
5. Does the athlete have history of seizures? YES NO
6. Does the athlete have only one of any paired organ (eyes, ears, kidneys, testicles, ovaries, etc.)? YES NO
7. Do you have any skin problems other than acne? YES NO
8. Has the athlete ever suffered a heat-related illness (heat exhaustion or heat stroke)? YES NO
9. Have you ever had a head injury, been knocked out, lost your memory, had your 'bell rung', or concussion? YES NO
10. Have you had mononucleosis or any significant illness in the last 60 days? YES NO
11. Do you wear glasses or contacts? YES NO
12. Does athlete have trouble with hearing/wear hearing aid(s)? YES NO
13. Are you currently taking any medicines or do you take any medicines on a regular basis (prescription or over-the-counter)? YES NO
14. Have you ever taken any supplements or vitamins to help with weight loss/gain or improve performance? YES NO
15. Do you have any allergies (seasonal/insects/food/medicines)? YES NO
16. Do you want to weigh more or less than you do now? YES NO
17. Do you lose weight regularly to meet weight requirements for you sport or other reasons? YES NO
18. Do you feel stressed out, tired, or depressed? YES NO
19. Have you ever been denied or restricted from participation in sports? YES NO
20. Are there any other issues you would like to discuss with a healthcare professional? YES NO

FEMALES ONLY

YES NO

21. Are your periods irregular (not every month)? YES NO
22. Are your periods heavy? YES NO

Cardiovascular History

YES NO

1. Do you cough, wheeze or have extreme trouble breathing with exercise? YES NO
2. Do you use an inhaler? YES NO
3. Ever passed out/nearly passed out during/after exercise? YES NO
4. Ever been dizzy during or after exercise? YES NO
5. Ever had chest pain/discomfort during or after exercise? YES NO
6. Do you tire more easily or more quickly than your friends during exercise? YES NO
7. Ever had a racing of your heart or skipped heartbeats? YES NO
8. Ever been told you had a heart murmur? YES NO
9. Ever been told you have high blood pressure? YES NO
10. Has any member of your family:
 - Died of heart problems or sudden death before age 50? YES NO
 - Been told they had a serious heart problem before age 50? YES NO
 - Been told they had Marfan's syndrome? YES NO
 - Hypertrophic or dilated cardiomyopathy? YES NO
 - Heart rhythm abnormality? YES NO

Orthopedic History

YES NO

1. Has the athlete ever broken or fractured any bones? YES NO
2. Has the athlete ever subluxed or dislocated any joint? YES NO
3. Have you ever had a stinger, burner, or pinched nerve? YES NO
4. Have you had any other problems related to your:
 - Neck, spine, or back? YES NO
 - Shoulders? YES NO
 - Elbows? YES NO
 - Wrists, hands, fingers? YES NO
 - Hips? YES NO
 - Knees? YES NO
 - Ankles, feet, or toes? YES NO
 - Other? YES NO

Please explain "Yes" answers in the space below. Please put date(s) of any injuries along with explanation:

CERTIFICATION / MEDICAL AUTHORIZATION

We certify that all of the information provided by us on this form is correct. We agree by the rules of the NCDPI and CMS. We give our consent for the student-athlete to receive a medical screening prior to participation in athletics and **acknowledge that this is simply a screening evaluation and not suitable for regular health care.** If the student-athlete is injured while participating in athletics and CMS is unable to contact the parent, we grant CMS permission and the authority to obtain necessary medical care and/or treatment for the student's injury including first aid, CPR, medical or surgical treatment recommended by a physician and we accept the financial responsibility for such medical care or treatment.

We (student and parents) certify that the home address shown in this document is the student's sole bona fide residence, and we will notify the school principal immediately of any change in residence, since such a move may alter the eligibility status of the student athlete. All information contained in this form is accurate and correct.

Student-Athlete: _____ Date: _____
(Signature)

Parent/Guardian: _____ Date: _____
(Please Print Name)

Parent/Guardian: _____ Date: _____
(Signature)



Page 3 of this document must be completed by a Physician, Physician's Assistant or Nurse Practitioner



Name (First, MI, Last): _____ CMS Student ID # _____

PHYSICAL EXAMINATION: To be completed by a Physician, Physician's Assistant or Nurse Practitioner ONLY

Height: _____ Weight: _____ Pulse: _____ Blood Pressure (sitting): (arm) _____ (leg) _____
 Right 20 / _____ Left 20 / _____ Corrected: Y N Body Fat% (opt.): _____ UA (opt.): _____

	Normal	Abnormal Findings	Initials
General Medical			
Appearance/Emotional Affect			
Head/Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart (standing/supine)			
Pulses (include femoral)			
Lungs			
Abdomen (include liver, spleen)			
Skin			
Neurologic (Balance, Coordination)			
Genitalia (males only)			
Orthopedic Record if any laxity, weakness, instability, decreased ROM			
Cervical/Spine			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			
Cardiologic (optional)			
EKG			
Echocardiogram			
Neurologic (optional)			
Baseline Neuropsychological Testing			

CLEARANCE

I, _____, undersigned, certify that I have examined this student-athlete and find him/her medically:

- Cleared
- Deferred until: (e.g. Rehab, consultation, lab, referral, etc.) _____
- May participate in the following sport(s) ONLY: (CHECK ALL THAT APPLY)
- _____ Contact/Collision _____ Limited Contact _____ Non-Contact/Strenuous _____ Non-Contact/Non-Strenuous

Classification of Sports by Contact			
Contact/Collision	Limited Contact	Non-Contact	
		Strenuous	Non-Strenuous
<input type="checkbox"/> Football	<input type="checkbox"/> Baseball/Softball	<input type="checkbox"/> Discus, Javelin, Shot Put	<input type="checkbox"/> Golf
<input type="checkbox"/> Soccer	<input type="checkbox"/> Basketball	<input type="checkbox"/> Running/Cross Country	
	<input type="checkbox"/> Cheerleading	<input type="checkbox"/> Swimming	
	<input type="checkbox"/> Volleyball	<input type="checkbox"/> Tennis	
	<input type="checkbox"/> High Jump, Pole Vault	<input type="checkbox"/> Strength Training	

Please specify each condition requiring clearance before participating in a sport in the classification checked above:

Not cleared Due to: _____

The following are considered disqualifying, but not limited to, until medical and parental releases are obtained: Atlantoaxial instability; Bleeding disorder; Hypertension; Dysrhythmia; Mitral valve prolapse; Acute infections; Obvious growth retardation; Diabetes mellitus; Jaundice; Severe visual or auditory impairment; Pulmonary insufficiency; Organ transplant recipient; Enlarged liver or spleen; Hernia; Musculoskeletal deformity associated with functional loss; History of convulsions or repeated concussions; Absence of one kidney, eye, testicle, ovary, etc.

Physician's Name: _____

ss: _____

Phone: _____

Signature _____ MD PA

NP

Physician Office Stamp:

Date of exam: _____

MIDDLE SCHOOL FOOTBALL ONLY GREEN FORM

NOTICE AND RELEASE

IMPORTANT: THIS NOTICE AND RELEASE MUST BE SIGNED AND RETURNED BEFORE YOUR STUDENT-ATHLETE CAN PARTICIPATE IN THE MIDDLE SCHOOL FOOTBALL PROGRAM.

To: Parents of students interested in participating in the Middle School Football Program

Subject: Student Accident Insurance – Middle School Football

Please read this Notice and Release carefully and make sure that you understand its provisions before deciding whether to permit your student-athlete to participate in the Middle School Football Program.

1. The Charlotte-Mecklenburg School System provides accident insurance in the amount of \$25,000 at no charge for all students participating in the Middle School Football Program. **The Middle School Football accident insurance benefits provided by the school system will pay only toward those covered expenses in excess of expenses recoverable from other insurance.** This means that any applicable personal insurance that you may carry would apply first, and the Middle School Football Accident Insurance would apply only to those covered expenses not paid by your other insurance. If you do not have other insurance, the Middle School Football Accident Insurance will pay toward covered expenses up to \$25,000.
2. There are limitations under the Middle School Football Accident Insurance coverage. **It will not always pay all of the charges incurred for every accident.** This insurance only provides certain benefits for injury or loss due to practicing and playing in the Middle School Football program. For a summary of the coverage benefits, please refer to the Student Accident Insurance Information (for Middle School Football) that has been furnished to each student interested in participating in the Middle School Football Program. If you did not receive the information or if you have questions about the insurance coverage provided to participants in the Middle School Football Program, contact the Athletic Director/Coach where your student-athlete is enrolled.
3. Every player is required by the National Federation of State High School Athletic Associations (NFSHSAA) regulations to wear a mouth guard. An additional \$150.00 per sound natural tooth is available for any player who sustains injuries to their teeth as a result of the failure of the mouth guard, provided that they were wearing the required mouth guard at the time of the injury.

PLEASE COMPLETE THE BACK OF THE FORM

MIDDLE SCHOOL FOOTBALL ONLY GREEN FORM

4. To be eligible for practice or participation in the Middle School Football Program, each participant must receive an **ANNUAL MEDICAL EXAMINATION** and return a physical examination form each calendar year (once every 365 days if signed before 1/1/2016 or once every 395 days if signed after 1/1/2016) signed by a physician licensed to practice medicine.
5. Neither the Board of Education nor any of its employees assumes any responsibility for claims resulting from injury to your Student Athlete while they are participating in the Middle School Football Program. This means that you will have to pay for any medical expenses not covered by the Middle School Football Accident Insurance, any personal insurance coverage that you might have and/or any other applicable insurance.

I, _____, (print name) hereby state that I have read and understand the provisions of this Notice and Release as well as the Student Accident Insurance information for the Middle School Football Accident Insurance coverage. I also state that prior to signing this document, I have had an opportunity to ask questions and that my questions have been answered to my satisfaction. I acknowledge that neither the Board of Education nor any of its employees assumes any responsibility for claims resulting from injury to my Student-Athlete while they are participating in the Middle School Football Program. In consideration of my Student-Athlete being permitted to participate in the Middle School Football Program, I **hereby waive, release, and forever discharge** the Charlotte-Mecklenburg Board of Education and its employees from any responsibility for claims resulting from injuries to my Student-Athlete due to their participation in the Middle School Football Program. I also state that my Student-Athlete has received a Medical Examination and has returned a physical examination form in compliance with the policy set forth in paragraph 4 of this Notice and Release. I certify that I consent to have my Student-Athlete participate in the Middle School Football Program offered at their school.

SIGNED: (Parent or Legal Guardian) _____ **Date** _____

Address: _____

Student's Full Name: _____

School: _____

2016

2017

NOTICE AND RELEASE

IMPORTANT: THIS NOTICE AND RELEASE MUST BE SIGNED AND RETURNED BEFORE YOUR SON/DAUGHTER CAN PARTICIPATE IN THIS PROGRAM.

TO: Parents of students interested in participating in Athletics

SUBJECT: Student Accident Insurance for Athletics

SPORT (S): _____

Please read this Notice and Release carefully and make sure that you understand its provisions before deciding whether to permit your son or daughter to participate in middle or senior high athletics.

1. Board of Education policy requires that the Student Accident Insurance offered by the school system, will be required for all students participating in middle and senior high school athletics unless an insurance waiver form is signed by the parent indicating adequate personal insurance and releasing the Board of Education and its employees from responsibility for any claim due to injuries received while participating in a school sponsored athletic program.
2. There are limitations in the Student Accident Insurance coverage. **IT WILL NOT ALWAYS PAY ALL OF THE CHARGES INCURRED FOR EVERY ACCIDENT.** For a summary of the coverage and benefits provided by the Student Accident Insurance, please read the current Student Accident Insurance Brochure that was furnished to each student at the beginning of the school year. If you did not receive the brochure or if you have questions about the insurance coverage provided under the policy, contact the Athletic Director at the school where your son/daughter is enrolled.
3. To be eligible for practice or participation in any school athletic program, each participant must receive an **ANNUAL MEDICAL EXAMINATION** and return a physical examination form each calendar year (once every 365 days if signed before 1/1/2016 or once every 395 days if signed after 1/1/2016) signed by a physician licensed to practice medicine.
4. Neither the Board of Education nor any of its employees assumes any responsibility for claims resulting from injury to your son/daughter while he or she is participating in the school athletic program. This means that you will have to pay for any medical expenses not covered by the Student Accident Insurance, any personal insurance coverage that you might have and/or any other applicable insurance.

PLEASE COMPLETE THE BACK OF THE FORM

I, _____, (print name) hereby state that I have read and understand the provisions of this Notice and Release as well as the Student Accident Insurance Brochure. I further state that prior to signing this document, I have had an opportunity to ask questions and that my questions have been answered to my satisfaction. I acknowledge that neither the Board of Education nor any of its employees assumes any responsibility for claims resulting from injury to my son/daughter while he or she is participating in the school athletic program. **I HEREBY WAIVE, RELEASE, AND DISCHARGE** the Charlotte-Mecklenburg Board of Education and its employees from any responsibility for claims resulting from injuries to my son/daughter due to his or her participation in this athletic program. I hereby certify that my son/daughter has received a **MEDICAL EXAMINATION** and has returned a physical examination form in compliance with the policy set forth in paragraph 3 of this Notice and Release. I certify that I consent to have my son/daughter participate in school athletic activity as identified on this Notice and Release. I make the following representation and selection (check one, sign and return promptly):

_____ I have adequate personal insurance that will cover injuries that might be sustained by my son/daughter as a result of his/her participation in the school athletics. I understand that in the event my son/daughter sustains any injuries as a result of his/her participation in school athletics, I am responsible for payment of medical expenses or other items not covered by any personal insurance.

_____ My son/daughter has enrolled in the Student Accident Insurance Program on ____/____/____, and I understand that in the event my son/daughter sustains any injuries as a result of his/her participation in school athletics, I am responsible for payment of any medical expenses or other items not covered by the Student Accident Insurance.

SIGNED: (Parent or Legal Guardian) _____ **Date** _____

ADDRESS: _____

STUDENT'S FULL NAME: _____

SCHOOL: _____

Gfeller-Waller NCHSAA Student-Athlete & Parent/Legal Custodian Concussion Information Sheet

What is a concussion? A concussion is an injury to the brain caused by a direct or indirect blow to the head. It results in your brain not working as it should. It may or may not cause you to black out or pass out. It can happen to you from a fall, a hit to the head, or a hit to the body that causes your head and your brain to move quickly back and forth.

How do I know if I have a concussion? There are many signs and symptoms that you may have following a concussion. A concussion can affect your thinking, the way your body feels, your mood, or your sleep. Here is what to look for:

Thinking/Remembering	Physical	Emotional/Mood	Sleep
Difficulty thinking clearly	Headache	Irritability-things bother you more easily	Sleeping more than usual
Taking longer to figure things out	Fuzzy or blurry vision	Sadness	Sleeping less than usual
Difficulty concentrating	Feeling sick to your stomach/queasy	Being more moody	Trouble falling asleep
Difficulty remembering new information	Vomiting/throwing up	Feeling nervous or worried	Feeling tired
	Dizziness	Crying more	
	Balance problems		
	Sensitivity to noise or light		

Table is adapted from the Centers for Disease Control and Prevention (<http://www.cdc.gov/concussion/>)

What should I do if I think I have a concussion? If you are having any of the signs or symptoms listed above, you should tell your parents, coach, athletic trainer or school nurse so they can get you the help you need. If a parent notices these symptoms, they should inform the school nurse or athletic trainer.

When should I be particularly concerned? If you have a headache that gets worse over time, you are unable to control your body, you throw up repeatedly or feel more and more sick to your stomach, or your words are coming out funny/slurred, you should let an adult like your parent or coach or teacher know right away, so they can get you the help you need before things get any worse.

What are some of the problems that may affect me after a concussion? You may have trouble in some of your classes at school or even with activities at home. If you continue to play or return to play too early with a concussion, you may have long term trouble remembering things or paying attention, headaches may last a long time, or personality changes can occur. Once you have a concussion, you are more likely to have another concussion.

How do I know when it's ok to return to physical activity and my sport after a concussion? After telling your coach, your parents, and any medical personnel around that you think you have a concussion, you will probably be seen by a doctor trained in helping people with concussions. Your school and your parents can help you decide who is best to treat you and help to make the decision on when you should return to activity/play or practice. Your school will have a policy in place for how to treat concussions. You should not return to play or practice on the same day as your suspected concussion.

You should not have any symptoms at rest or during after activity when you return to play, as this is a sign your brain has not recovered from the injury.

This information is provided to you by the UNC Matthew Gfeller Sport-Related TBI Research Center, North Carolina Medical Society, North Carolina Athletic Trainers' Association, Brain Injury Association of North Carolina, North Carolina Neuropsychological Society, and North Carolina High School Athletic Association.

Last Updated May 2016

Gfeller-Waller NCHSAA Student-Athlete & Parent/Legal Custodian Concussion Statement Form

Instructions: The student athlete and his/her parent or legal custodian, must initial beside each statement acknowledging that they have read and understand the corresponding statement. The student-athlete should initial in the left column and the parent or legal custodian should initial in the left column. Some statements are applicable only to the student-athlete and should only be initialed by the student-athlete. This form must be completed for each student-athlete, even if there are multiple student-athletes in the household.

Student-Athlete Name: (please print) _____

Parent/Legal Custodian Name(s): (please print) _____

Student-Athlete Initials		Parent/Legal Custodian(s) Initials
	A concussion is a brain injury, which should be reported to my parent(s) or legal custodian(s), my or my child's coach(es), or a medical professional if one is available.	
	A concussion cannot be "seen." Some signs and symptoms might be present immediately; however, other symptoms can appear hours or days after an injury.	
	I will tell my parents, my coach and/or a medical professional about my injuries and illnesses.	Not Applicable
	If I think a teammate has a concussion, I should tell my coach(es), parent(s)/ legal custodian(s) or medical professional about the concussion.	Not Applicable
	I, or my child, will not return to play in a game or practice if a hit to my, or my child's, head or body causes any concussion-related symptoms.	
	I, or my child, will need written permission from a medical professional trained in concussion management to return to play or practice after a concussion.	
	Based on the latest data, most concussions take days or weeks to get better. A concussion may not go away, right away. I realize that resolution from a concussion is a process that may require more than one medical visit.	
	I realize that ER/Urgent Care physicians will not provide clearance to return to play or practice, if seen immediately or shortly after the injury.	
	After a concussion, the brain needs time to heal. I understand that I or my child is much more likely to have another concussion or more serious brain injury if return to play or practice occurs before concussion symptoms go away.	
	Sometimes, repeat concussions can cause serious and long-lasting problems.	
	I have read the concussion symptoms listed on the Student-Athlete/ Parent Legal Custodian Concussion Information Sheet.	
	I have asked an adult and/or medical professional to explain any information contained in the Student-Athlete & Parent Concussion Statement Form or Information Sheet that I do not understand.	

By signing below, we agree that we have read and understand the information contained in the Student-Athlete & Parent/Legal Custodian Concussion Statement Form, and have initialed appropriately beside each statement.

Signature of Student-Athlete

Date

Signature of Parent/Legal Custodian

Date



Charlotte-Mecklenburg Schools
Application for Waiver of Athletic Participation Fee

In June 2010, the Board of Education approved participation fees for middle and high school athletic teams. Middle school students pay a fee of \$75.00 and high school students pay a fee of \$125.00 for each interscholastic sports season in which they participate on one or more teams. Payment of this fee is required by a deadline which is established for each sports season.

In June 2014, the Board of Education approved CMS to participate in the federal Community Eligibility Provision (CEP). The CEP eliminates the need for a district to qualify students for free and reduced price meals and track which students are participating. Students are identified as directly certified (through data matching) for free meals because they live in households that participate in Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TNAF), or Food Distribution Program on Indian Reservations (FDPIR), as well as children who are qualified for free schools meals without submitting a school meal application because of their status as being in foster care, enrolled in Head Start, homeless, runaway, or migrant students.

Students identified as directly certified are eligible to have their participation fee waived. No other students are eligible for this fee waiver. Each applicant's directly certified status is current and must be verified by Child Nutrition Services. Each applicant's waiver form must be accompanied by a current copy of the CMS Child Nutrition meal eligibility letter or a benefits letter from DSS before the athletic participation fee can be waived.

If you wish to apply for a fee waiver, please fill out the information below and return this form to your child's athletic director or athletic coach.

Partially completed forms will not be accepted.

A separate form must be filled out for each student-athlete for whom a waiver is requested.

Name of student [please print]
Student ID number [please print]
School [please print]
Parent/guardian name [please print]
Address [please print]
Number/Street City, State, Zip

I hereby apply for a waiver of the CMS athletic participation fee and affirm the information provided on and with this application is accurate.

Parent/Guardian (Print Name)

Parent/guardian signature

Date