



# CARDINAL NEWMAN HIGH SCHOOL

512 Spencer Drive • West Palm Beach, Florida 33409-3616  
Telephone (561) 683-6266 • Facsimile (561) 683-7307  
www.cardinalnewman.com

## STUDENT PARTICIPATION AND PARENTAL APPROVAL FORM (REQUIRED ONLY FOR ATHLETES)

NAME OF STUDENT \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

This application to compete in interscholastic athletics for the above high school is entirely voluntary on my part and is made with the understanding that I have not violated any of the eligibility rules and regulations of the Florida High School Activities Association.

Signature of Student \_\_\_\_\_ Date \_\_\_\_\_

### PARENTS' OR GUARDIANS' PERMISSION (TWO PARENT OR TWO GUARDIAN SIGNATURES REQUIRED WHERE APPLICABLE)

I hereby give my consent for the above named student (1) to represent his/her school in athletic activities with the exception of any activities not approved for my child by his doctor and so stated on the required health report, provided that such athletic activities are approved by the Florida High School Activities Association; (2) to accompany any school team of which he/she is a member or any of its local or out-of-town trips. I authorize the school to obtain, through a physician of its own choice, any emergency medical care that may become reasonably necessary for the student in the course of such athletic activities or such travel. I also agree not to hold the school or anyone acting in its behalf or the Florida High School Activities Association responsible to any injury occurring to the above named student in the course of such athletic activities or such travel.

Signature of Parent or Guardian \_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_  
Area Code \_\_\_\_\_

Home Phone \_\_\_\_\_  
Area Code \_\_\_\_\_

### MEDICAL TREATMENT RELEASE FORM

I, \_\_\_\_\_ give Cardinal Newman High School and all FHSAA designated representatives,  
Name of Parent or Guardian

**LIST ALL SPORTS ATHLETE WILL  
PARTICIPATE IN DURING CURRENT  
SCHOOL YEAR**

Sport \_\_\_\_\_ Coach \_\_\_\_\_

Sport \_\_\_\_\_ Coach \_\_\_\_\_

Sport \_\_\_\_\_ Coach \_\_\_\_\_

permission to transport and sign all forms related to the necessary medical treatment for \_\_\_\_\_ I also permit any  
and all required medical treatment to be administered by qualified medical personnel.  
Name of Athlete

List the medication the participant is taking: \_\_\_\_\_

List the medication the participant is **allergic** to: \_\_\_\_\_

Father's Business Phone \_\_\_\_\_

Mother's Business Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Relationship \_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_

Date \_\_\_\_\_

Signed before me this \_\_\_\_\_ day of \_\_\_\_\_ in the year of 20\_\_\_\_. The State of Florida, the County of Palm Beach.

Personally known \_\_\_\_\_ or Produced Identification \_\_\_\_\_ Type of Identification Produced \_\_\_\_\_

SEAL \_\_\_\_\_  
Notary's Signature

\_\_\_\_\_  
My commission Expires

**THIS FORM IS TO BE FILLED OUT COMPLETELY AND RETURNED TO CENTRAL OFFICE NO LATER THAN THE FIRST DAY OF PRACTICE.**