



Georgia Avenue Campus

3600 Georgia Avenue, NW
Washington, DC 20010
(202) 667-4446 (Grades 4-8)

Kansas Avenue Campus

4501 Kansas Avenue, NW
Washington, DC 20011
(202) 706-5828 (Grades PS-3)
(202) 706-5838 (Grades 9-12)

info@elhaynes.org
www.elhaynes.org

Tryout & Conditioning Permission Form

Season: fall / winter / spring (Coach Circles) **Level:** Varsity / JV / Freshman / MS Year: 20_____

Sport: Soccer / Basketball / Flag Football / Cross Country / Track / Other: _____

In order to participate in tryout or participate in conditioning for competitive sports, parents/guardians must complete this document (Pages 1 & 2) prior to participating.

(Coach fills the below in)

Date(s) or Days of tryout: _____
(Coach fills in)

Time(s) of tryout: _____
(Coach fills in)

Location of tryout: _____
(Coach fills in)

Tryout Attire: Student-Athletes need to come prepared with this required equipment to participate:

(Coach fills in)

Please sign and return this entire form by (Date) _____ to the head coach . *Students without signed forms will not be allowed to participate in conditioning workouts or tryouts.*

Additional Notes from the coach:

Parents Section:

I give my child permission to participate in _____ try-outs and/or conditioning workouts. My child, (first & last name) _____, has my permission to go to the try out for _____ on (days / dates times) _____ at (location) _____.

After each session my child has permission to leave field on own: Yes _____ No _____

I will pick my child up each day: Yes _____ No _____

Parent/Guardian Name (PRINT) _____ Phone Number: _____

Parent/Guardian (Signature) _____

Date _____

Over →



PLEASE TYPE OR PRINT

**EL Haynes Athletics Emergency Form
AUTHORIZATION FOR CHILD'S EMERGENCY MEDICAL TREATMENT**

If my child _____, born on _____, becomes ill or involved in an accident and I cannot be contacted, I authorize the following hospital or physician to give the emergency medical treatment required:

Hospital: _____

Address: _____

or:

Physician: _____ M.D. **Telephone No:** _____
(Area Code)

Address: _____

I give permission to E.L. Haynes Public Charter School, located at 3600 Georgia Ave. NW, Washington. DC 20010 & 4501 Kansas Ave. NW, Washington, DC 20011 to take my child for treatment.

I accept responsibility for any necessary expense incurred in the medical treatment of my child, which is not covered by the following:

Health Insurance Company: _____

Name of Policy Holder: _____ **Relationship to Child:** _____

Policy Number: _____ **Coverage:** _____

Medicaid Number: _____ **State:** DC MD VA

Child's Known Allergies or Physical Conditions: _____

Signature: _____ **Relationship to Child:** _____

Address: _____

Telephone No: _____
Home _____ **Business** _____ **Pager/Cell Phone** _____

Date: _____ **Date Updated:** _____
Month/Day/Year Month/Day/Year