

Please Return This Form To The Athletics Office

LEXINGTON HIGH SCHOOL

USER FEE FORM

Student Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address \_\_\_\_\_ Grade \_\_\_\_\_

**High School Interscholastic Sport User Fees:**  
\$300.00 1<sup>st</sup> sport per student  
\$300.00 2<sup>nd</sup> sport per student  
3<sup>rd</sup> sport free  
\$600.00 Maximum per family

Make checks payable to: The Town of Lexington

Send or bring to: Lexington High School  
251 Waltham Street  
Lexington MA 02421

Family Plan: If user fees for school athletics exceeds \$600.00 for your entire family, grades 5 – 12, you qualify for the family plan. Please provide the following information and send it to the above address with a check for \$600.00

Student Names (first, last)	Grade	School
_____	_____	_____
_____	_____	_____
_____	_____	_____

\*\*\*\*\* MIDDLE SCHOOL USER FEES \*\*\*\*\*

Varsity sports: \$100.00 per sport  
Junior Varsity sports: \$65.00 per sport  
Intramural programs: \$60.00 per session

\*\*\*\*\* ELEMENTARY SCHOOL USER FEES \*\*\*\*\*

Before School Sports Program: \$100.00 per year

**FEE WAIVERS:** The user fee can be waived for extenuating financial circumstances. Parents must fill out a waiver request form and submit it to the students' school Principal.

LEXINGTON PUBLIC SCHOOLS DEPARTMENT OF ATHLETICS AND PHYSICAL EDUCATION

**PARENT PERMISSION FORM**

Parents / Guardians: Please carefully complete the front and back of this form. It will be used to help ensure the safety of your child while participating in an interscholastic sports program. All information is confidential and will be used only for the purpose of evaluating your child's health status and for facilitating medical care or treatment in an emergency.

Student name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Grade \_\_\_\_\_

Address: \_\_\_\_\_ Home phone: \_\_\_\_\_

Date of last physical: \_\_\_\_\_

**CIRCLE THE SPORT YOU WILL PLAY THIS SEASON**

- |                       |                         |               |
|-----------------------|-------------------------|---------------|
| Football              | Basketball              | Baseball      |
| Soccer                | Wrestling               | Softball      |
| Field Hockey          | Boys Swimming           | Tennis        |
| Girls Swimming        | Hockey                  | Lacrosse      |
| Volleyball            | Indoor Track            | Outdoor Track |
| Cross Country         | Basketball Cheerleading |               |
| Golf                  | Hockey Cheerleading     |               |
| Football Cheerleading |                         |               |
| Soccer Cheerleading   |                         |               |

Parent/Guardian name: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Address: \_\_\_\_\_ Work phone: \_\_\_\_\_

Physician name: \_\_\_\_\_ Town: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist name: \_\_\_\_\_ Town: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Member I.D. #: \_\_\_\_\_

1) Has the student had a serious illness or surgery during the last 3 years? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

2) Is the student currently under medical care for any condition? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Contact lenses? Yes \_\_\_\_\_ No \_\_\_\_\_ ( Turn form Over)

**PLEASE SIGN AND COMPLETE FORM ON OTHER SIDE**

LEXINGTON PUBLIC SCHOOLS DEPARTMENT OF ATHLETICS AND PHYSICAL EDUCATION

**PARENT PERMISSION FORM**

Student / child's name: \_\_\_\_\_

Medical restrictions: \_\_\_\_\_

Allergies: \_\_\_\_\_ Medications: a. \_\_\_\_\_

Does your child need an **EpiPen**? \_\_\_\_\_ b. \_\_\_\_\_

c. \_\_\_\_\_

Is the **EpiPen** with him/her at all times? \_\_\_\_\_

It is required that students with life threatening allergies have an EpiPen with them at all times during interscholastic sports.

I verify that the above information is correct and give permission for my child to participate in the interscholastic sports program. I understand that in case of injury The Lexington School Department is responsible **only** for first aid treatment and efforts will be made to contact the parents/guardian should an injury occur. In the event of an **emergency**, and timely treatment is of great importance, and school officials are not able to contact me promptly, I authorize the school authorities to exercise their best judgment for my child's welfare and give my consent for emergency treatment to be initiated by calling 911 and permit my child to be transported to the nearest medical facility.

\_\_\_\_\_ My personal medical insurance is adequate to cover all medical costs.

\_\_\_\_\_ I have subscribed to the regular school insurance offered in addition to my personal insurance.

Signature of  
Parent / Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

DEPARTMENT OF PHYSICAL EDUCATION & ATHLETICS  
LEXINGTON PUBLIC SCHOOLS

**ATHLETIC USER FEE WAIVER / REDUCTION REQUEST FORM**

The Lexington Public Schools encourages students to participate in the interscholastic athletic program and tries to make every effort not to deny this opportunity based on families' financial needs. When payment of the athletic user fee places an undue hardship on the family, a waiver or reduction of the fee may be applied for by **completely** filling out this form, signing it, and returning it to Dr. Michael Jones, Principal, Lexington High School. Only one request form needs to be filled out per family. Please list names of ALL family members on this form.

Parent's Name: \_\_\_\_\_

Gross Monthly Earnings Before Deductions (total of all employment): \_\_\_\_\_

Monthly Welfare Payments, Child Support, Alimony Payments: \_\_\_\_\_

Monthly Pensions, Retirement, Social Security Payments: \_\_\_\_\_

Any Other Monthly Income: \_\_\_\_\_

Please fill in this information for all members of your household:

Name	Age	Grade	School	Monthly Income
1. _____				
2. _____				
3. _____				
4. _____				
5. _____				
6. _____				
7. _____				
8. _____				

PLEASE COMPLETE THE BACK SIDE OF THIS FORM

