

# ATHLETIC PARTICIPATION / PERMISSION FORM

*This form is to be filled-out completely by Parent & Physician before the student can participate in the school athletic programs.*

PRESENT DATE: \_\_\_\_\_

STUDENT'S NAME: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

SCHOOL: \_\_\_\_\_ GRADE: \_\_\_\_\_

ADDRESS OF STUDENT: \_\_\_\_\_  
\_\_\_\_\_

HOME PHONE #: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

PARENT'S NAME: \_\_\_\_\_ Parent's Work Phone:(Mother)# \_\_\_\_\_

(Father)# \_\_\_\_\_

I, hereby, apply for Permission to Participate IN the following interscholastic SPORT(s): *(EXAMPLE: Baseball, Tennis, XC, etc...)*

\*I certify that the information in this application is correct, and I agree to abide by the eligibility rules & regulations governing athletics as set forth by the North Carolina State Board of Education & Association to which my school is a member.

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

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## MEDICAL HISTORY - (to be completed by Parents)

STUDENT NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ Today's DATE: \_\_\_\_\_

**\*Is there any known history of:**

**If "Yes" Explain:**

- |   |           |          |       |
|---|-----------|----------|-------|
| A. Birth deformities <i>(one eye, one kidney, etc.)</i> | Yes _____ | No _____ | _____ |
| B. Past illness of more than one week's duration?       | Yes _____ | No _____ | _____ |
| C. Medical conditions currently under treatment?        | Yes _____ | No _____ | _____ |
| D. Fractures or other disabling injuries?               | Yes _____ | No _____ | _____ |
| E. Any permanent deformity or disability?               | Yes _____ | No _____ | _____ |
| F. Allergy <i>(drugs, food, clothing, etc.)?</i>        | Yes _____ | No _____ | _____ |
| G. Mental disorder or convulsions?                      | Yes _____ | No _____ | _____ |

*If you need more room to explain any above questions answered "Yes:"* \_\_\_\_\_

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## PARENTAL PERMISSION - (to be completed by Parents)

As Parent or Legal Guardian of: \_\_\_\_\_, I hereby give my consent for his/her practice & play in the athletic events/sports listed above.

I also grant permission for treatment deemed necessary for a condition arising during participation in these activities, including Medical or Surgical Treatment recommended by a Medical Doctor. I understand that every effort will be made to contact me prior to treatment.

I agree to the need for a screening Medical Examination and certify that the medical history is accurate to the best of my knowledge.

If your child/student should need emergency care immediately please indicate which Physician & Hospital you wish for us to transport him/her to. We will also need the following Insurance and Emergency information:

Is your son/daughter presently covered by a Hospital Insurance policy? Yes \_\_\_\_\_ No \_\_\_\_\_  
(You will be required to purchase Insurance for your child if your answer is "NO" to the question above.)

Health Insurance Company Name: \_\_\_\_\_

Insurance Policy # \_\_\_\_\_

Indicate Hospital Preference: \_\_\_\_\_

Physician's Name & Office Phone #: \_\_\_\_\_

Signature of Parent or Legal Guardian: \_\_\_\_\_ Date \_\_\_\_\_

Parent's Emergency Phone #'s: \_\_\_\_\_

[Other person(s) you would like us to contact: \_\_\_\_\_ # \_\_\_\_\_  
in the event you cannot be reached]: \_\_\_\_\_ # \_\_\_\_\_