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…)*

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*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 *(one eye, one kidney, etc.).*	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 *(drugs, food, clothing, etc.)?*	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]: ____**#**______________________