ATHLETIC PARTICIPATION/PERMISSION FORM

This form is to be filled out completely by parent and physician and filed in the office of the principal before the student can participate in the school athletic programs.

PRESENT DATE:_________________________________

STUDENT'S NAME____ **S/S#** ___________________________

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): Soccer, Volleyball, Basketball, Baseball, Track, Softball, Cheerleading.

I certify that the information in this application is correct, and I agree to abide by the eligibility rules and regulations governing athletics as set forth by New Life Christian School and the Mason Dixon Christian Conference to which my school is a member.

Signature of Student____

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MEDICAL HISTORY *(to be completed by parents)*

STUDENT NAME__________________________________ AGE__________ DATE____________

<u>Is there any known history of:</u> **<u>If "Yes" Explain:</u>**

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 and play in the athletic events 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 we will need the following Insurance and Emergency information:

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/people you would like us to contact ___________________________________ #________________________

in the event you cannot be reached]: ___________________________________ #________________________

PHYSICAL FORM *(to be completed by a physician)*

Student's Name_____ Date of Birth_____

Height_____ Weight_____ Blood Pressure_____

	NORMAL	ABNORMAL	DESCRIBE ABNORMALITIES:
1. Eyes	_____	_____	_____
2. ENT	_____	_____	_____
3. Heart	_____	_____	_____
4. Lungs	_____	_____	_____
5. Abdomen	_____	_____	_____
6. Genitalis	_____	_____	_____
7. Muscularskeletal	_____	_____	_____
8. Neurological	_____	_____	_____
9. Skin	_____	_____	_____

LABORATORY

URINALYSIS:_____

OTHER (Where Indicated):_____

_____

_____

I certify that I have examined this student and find him medically qualified to compete in the interscholastic sports listed.

Licensed to practice medicine in MD ? Yes_____ No_____

Signature of Physician_____

Address _____

Physician Phone # _____

DATE OF PHYSICAL:_____

Physician; If the above named student is not qualified, please list reasons for disqualification:_____

_____

_____

(The following are considered disqualifying until medical and parental release are obtained: acute infections, obvious growth retardation, diabetes, jaundice, severe visual or auditory impairment, pulmonary insufficiency, organic heart diseases or hypertension, enlarged liver or spleen, hernia, muscularskeletal deformity associated with functional loss, history of convulsions, absence or one kidney, eye or testicle.)