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_____

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 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

_____

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.)