Athletic Eligibility Forms Packets

The on-line athletic eligibility forms packet contains most of the required documents for athletic eligibility. Forms must be completed in their entirety and require the signature of the student-athlete and the parent/guardian. The school athletic director will determine the deadline for the return of these forms at their school. These forms are required for participation in athletics at the school. Note: These forms do not constitute all required proofs/information for athletic participation.

Families have the option to

1. Complete the on-line forms and submit them to the school athletic director electronically; print the remaining forms and deliver them to the school athletic director when completed
2. Print the entire forms packet, complete all forms by hand, deliver the entire packet to the school athletic director when completed

INSTRUCTIONS

1. Complete each form in their entirety and type in your signature and date where noted. *Your electronic signature has the same legal effect and can be enforced in the same way as a written signature and by typing your name to the form you are electronically signing each document.*

2. The first seven (7) forms can be completed on-line. Note: athletes who participate in football and another sport(s) should complete both the football and the all other sport insurance forms. When these forms are completed in their entirety and signed, save the form package to your computer and email it to your school athletic director.
   Name the form: *sport-year-last name-first name*
   Example:volleyball-2018-smith-mary

3. Print and complete the remaining five (5) forms, add the required two proofs of residence and hand deliver the completed package to your school athletic director.
   a) Confirmation of Signed Athletic Eligibility Forms
   b) NCHSAA High School Pre-Participation Exam Form *(Requires signature of physician)*
   c) 2018-19 CMC Medical Release of Information-Student (English or Spanish)
   d) Child Nutrition notification letter from CMS child nutrition office
   e) Two (2) proofs of residence

4. Information you provide must be complete, accurate and truthful. False and/or inaccurate information may result in a 365-day athletic ineligibility period for the student-athlete who signs the forms.

I understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature and by typing my name, I am electronically signing this document.

Please speak with your school athletic director if you have questions about athletic eligibility.

Charlotte-Mecklenburg Schools High School Athletic Eligibility Certification Form
TAB THROUGH FORM & TYPE INFORMATION or PRINT FORM AND WRITE INFORMATION
(Completed and signed form is required prior to any athletic participation)

Name of student-athlete (*print*)**:** _____ **Sport**:_____ **Grade**:_____

Home Phone: _____ **Student Cell:**_____ **Parent / Legal Custodian Cell:**_____

Domicile: The fixed and permanent dwelling place where a person intends to live for an indefinite period of time. A person may have only one domicile and a minor's domicile is the same as his/her parents.

1. Domicile of student-athlete

Street Address – *please print* _____ City, State, Zip Code _____

2. Domicile of mother

Street Address – *please print* _____ City, State, Zip Code _____

3. Domicile of father - *if different from domicile of mother*

Street Address – *please print* _____ City, State, Zip Code _____

4. Domicile of legal custodian or hardship caregiver *(if applicable)*

Street Address – *please print* _____ City, State, Zip Code _____

RESIDENCY HISTORY

Name of all individuals who reside at the domicile of the student-athlete (*print*) | Relationship to Student-athlete (*print*)

_____ | _____
_____ | _____
_____ | _____

List other addresses where you have lived in the last 12 months. *Print* the street, house or apartment number, city and zip.

_____
_____
_____

PROOFS OF RESIDENCY

One document from **both** column A and column B must be submitted with this signed pre-participation form.
These documents are for address verification and must all reflect the address provided for residency eligibility.

Column A	Column B
• Copy of Deed OR record of most recent mortgage statement • Copy of full Lease (including Charlotte Housing Authority and HUD leases) and proof of most recent payment if the lease is outdated or month-to-month • HUD Closing Statement • Residency Affidavit from landlord affirming tenancy AND record of most recent rent payment, if applicable • Affidavit of Residence and Student Hardship Status • Section 8 agreement • Letter from approved agency (group & foster home purposes only)	A utility bill or work order dated within the past 30 days, including: • Gas bill • Telephone bill • Water bill • Cable bill • Electric bill **- OR -** Dated within the past 60 days: • Payroll stub • Bank or credit card statement **- OR -** Dated within the past year: • W-2 form • Vehicle tax bill • Property tax bill • Medicaid Card

ENROLLMENT HISTORY

Where did the student attend school the previous year? (*print*) _____

Student has been enrolled _____ consecutive semester(s) at _____ High School

The previous semester the student attended _____ School in _____ City, State

Student-athlete initially entered the ninth grade in the fall of (year) _____

CONVICTIONS

☐ Yes ☐ No Student has been convicted of or entered a plea of no contest to a felony

****

1. My signature certifies I have read and I understand the definition of domicile provided on this form
2. My signature certifies my domicile is located at the address listed on this form
3. My signature certifies the address provided on this form matches the address listed in Power School for the student-athlete and parent/legal custodian
4. My signature certifies the address provided has been my domicile since on or about the _____ day of _____ Date _____ Month _____ Year
5. My signature verifies all information provided on this form is accurate and true and that I agree to provide additional specific and current proofs of domicile if requested by school or district administration
6. My signature verifies I understand that failure to provide accurate and up-to-date information may be grounds for loss of athletic eligibility

_____ _____
SIGNATURE of Student-Athlete **Date**

_____ _____ _____
SIGNATURE of Parent or Legal Custodian/Guardian **Date** **Print Name of Parent or Legal Custodian/Guardian**

I understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature and by typing my name in the packet; I am electronically signing those documents.

Revised 5/16/14

Charlotte-Mecklenburg Schools
High School Student-Athlete Pre-Participation Form
TAB THROUGH FORM & TYPE INFORMATION OR PRINT FORM AND WRITE INFORMATION

PERSONAL & EMERGENCY CONTACT INFORMATION

Student-Athlete's Name (First, MI, Last): _____ CMS Student ID # _____

Gender: ☐ M ☐ F Date of Birth: _____ Age: _____ Home Phone: _____

Resides At Street Address: _____ City: _____ State: _____ Zip Code: _____ County: _____

Father's Name: _____ Daytime Phone: _____ Cell Phone: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____ County: _____

Mother's Name: _____ Daytime Phone: _____ Cell Phone: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____ County: _____

If applicable… Guardian's Name: _____ Daytime Phone: _____ Cell Phone: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____ County: _____

- If student-athlete resides with other than parent(s), attach legal documentation of custody (guardianship or affidavit provided by Student Placement)
- If parents are separated or divorced, provide proof of court custody. If no custody order is available, provide documentation signed by both parents showing address of record for the student-athlete

Failure to provide accurate and up-to-date residence information may be grounds for loss of athletic eligibility

Family Physician/Pediatrician: _____ Phone: _____

Preferred Hospital: _____ Permission to Transport: ☐ Yes ☐ No

SPORT (check all sports you are considering to participate in)

Fall	Winter	Spring
☐ Cheerleading	☐ Basketball - Men's	☐ Baseball
☐ Cross Country - Men's	☐ Basketball - Women's	☐ Golf - Men's
☐ Cross Country - Women's	☐ Cheerleading	☐ Lacrosse - Men's
☐ Football	☐ Indoor Track - Men's	☐ Lacrosse - Women's
☐ Golf - Women's	☐ Indoor Track - Women's	☐ Soccer - Women's
☐ Soccer - Men's	☐ Swimming/Diving - Men's	☐ Softball - Women's
☐ Tennis - Women's	☐ Swimming/Diving - Women's	☐ Tennis - Men's
☐ Volleyball - Women's	☐ Wrestling	☐ Track - Men's
Weightlifting may be a required component of conditioning for any sport.		☐ Track - Women's

INSURANCE

School Board Policy JLA requires that all students who participate in athletics be adequately covered by medical or accident insurance.
We acknowledge that it is the signed responsibility to notify CMS of any changes that occur to the personal insurance policy below and affect the procedures in which the above-named individual may receive treatment; this includes loss of coverage. We certify that we have purchased and will maintain in full force and effect during student-athlete's participation in athletics the following insurance policy:

Check One: ☐ School Accident Insurance ☐ Personal Insurance Company

Name of Insurance Company _____ Policy Number _____ Group Number _____

Insurance Phone for Authorization _____ Policy Holder _____

RELEASE

In consideration of CMS allowing the above-named individual to participate in athletics, we agree to release and hold CMS, its athletic coaches, and other employees free, harmless and indemnified from and against any and all claims, suits, or causes of action arising from or out of injury that the student-athlete may suffer from participation in athletics other than an injury from gross or willful negligence.

ASSUMPTION OF RISK

We acknowledge and understand that there is a risk of injury involved in athletic participation. We understand that the student-athlete will be under the supervision and the instructions of the coach in order to reduce the risk of injury to the student-athlete and other athletes. However, we acknowledge and understand that neither the coach nor CMS can eliminate the risk of injury in sports. Injuries may and do occur. *Sports injuries can be severe and in some cases may result in permanent disability or even death*. We freely, knowingly, and willfully accept and assume the risk of injury that might occur from participation in athletics.

HIPAA / FERPA RELEASE

The above named student-athlete has opted his/her rights under the US Department of Health and Human Resources guidelines. By signing this release, the student-athlete allows sharing of medical information between the Sports Medicine Staff (team physicians and medical staff, athletic trainers, and student assistants), the CMS Athletics Staff (Athletic Director and Coaches), CMS Administration and his/her medical provider(s). In the event of an emergency situation, information may be shared with emergency medical personnel. Every reasonable effort will be made to protect this information. It is understood that once this medical information is disclosed, it is no longer protected under the HIPAA/FERPA guidelines.

We (student and parents) certify that the home address shown in this document is the student-athlete's sole bona fide residence, and we will notify the school principal immediately of any change in residence, since such a move may alter the eligibility status of the student-athlete.
All information contained in this form is accurate and correct.

Student-Athlete Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

I understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature and by typing my name in the packet; I am electronically signing those documents.

Charlotte-Mecklenburg Schools
Interscholastic Athletics

Student-Parent Honor Code

This Honor Code must be initialed and signed before a student may dress and/or compete in an athletic contest.

STUDENT'S NAME (print)**:** _____

SCHOOL (print)**:** _____ **SPORT:** _____ **GRADE:** _____

PARENT/ LEGAL CUSTODIAN/ LEGAL GUARDIAN/ HARDSHIPCAREGIVER NAME (print)**:** _____

STUDENT'S DOMICILE (print)**:** _____ _____ _____
Number & Street | City/Town, State | Zip Code

I understand the eligibility requirements for the student named on the Honor Code to take part in interscholastic athletics in Charlotte-Mecklenburg Schools. If I had questions, the school athletic director answered them prior to my initialing/signing the Honor Code.

My initials and signature acknowledge that:

Student-Athlete *Initials*		**Parent, Legal Custodian, Legal Guardian or Hardship Caregiver** *Initials*
N/A	I am the parent, legal custodian or legal guardian of the student named above or I have been designated as the Hardship Caregiver by the CMS Student Placement Office.	
	ALL information I am providing on this Honor Code is the truth. My correct and current address is provided above. I understand that lying is cheating.	
	The address listed on this form, and provided to the school registrar & school athletic director where the student is enrolled, is where I actually live at the present time.	
	I currently live in the attendance area for the school listed on this Honor Code, or the student was assigned to the school listed on the Honor Code through the student assignment lottery, or the student received a transfer to the school.	
	I am not aware of any other students or parents who have given false information to CMS so they can participate on an athletic team.	
	I will immediately report all suspected athletic eligibility violations to the principal or athletic director at the school listed on this honor code.	
	I am aware that if I provide false information concerning athletic eligibility to the school and/or do not report information about known athletic eligibility falsifications of others that I may be penalized by the North Carolina High School Athletic Association (high school only) and by Charlotte-Mecklenburg Schools. I may lose the privilege of participation in athletics for 365 days and my team may have to forfeit contests.	N/A
N/A	I am aware that if I provide false information concerning athletic eligibility; do not report information about known athletic eligibility falsifications of others; and/or do not update my home address with the school registrar and athletic director the student-athlete listed above and his or her athletic team may be penalized by the North Carolina High School Athletic Association (high school only) and by Charlotte-Mecklenburg Schools, including losing the privilege of participation in athletics for 365 days and the team may have to forfeit contests.	

_____ _____
Signature of Student Listed Above | Date

_____ _____
Signature of Parent, Legal Custodian, Legal Guardian or Hardship Caregiver Listed Above | Date

I understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature and by typing my name in the packet; I am electronically signing those documents.

Revised 5/14/14

Gfeller-Waller NCHSAA Student-Athlete & Parent/Legal Custodian Concussion Information Sheet

What is a concussion? A concussion is an injury to the brain caused by a direct or indirect blow to the head. It results in your brain not working as it should. It may or may not cause you to black out or pass out. It can happen to you from a fall, a hit to the head, or a hit to the body that causes your head and your brain to move quickly back and forth.

How do I know if I have a concussion? There are many signs and symptoms that you may have following a concussion. A concussion can affect your thinking, the way your body feels, your mood, or your sleep. Here is what to look for:

Thinking/Remembering	Physical	Emotional/Mood	Sleep
Difficulty thinking clearly	Headache	Irritability-things bother you more easily	Sleeping more than usual
Taking longer to figure things out	Fuzzy or blurry vision	Sadness	Sleeping less than usual
Difficulty concentrating	Feeling sick to your stomach/queasy	Being more moody	Trouble falling asleep
Difficulty remembering new information	Vomiting/throwing up	Feeling nervous or worried	Feeling tired
	Dizziness	Crying more	
	Balance problems		
	Sensitivity to noise or light		

Table is adapted from the Centers for Disease Control and Prevention (http://www.cdc.gov/concussion/)

What should I do if I think I have a concussion? If you are having any of the signs or symptoms listed above, you should tell your parents, coach, athletic trainer or school nurse so they can get you the help you need. If a parent notices these symptoms, they should inform the school nurse or athletic trainer.

When should I be particularly concerned? If you have a headache that gets worse over time, you are unable to control your body, you throw up repeatedly or feel more and more sick to your stomach, or your words are coming out funny/slurred, you should let an adult like your parent or coach or teacher know right away, so they can get you the help you need before things get any worse.

What are some of the problems that may affect me after a concussion? You may have trouble in some of your classes at school or even with activities at home. If you continue to play or return to play too early with a concussion, you may have long term trouble remembering things or paying attention, headaches may last a long time, or personality changes can occur Once you have a concussion, you are more likely to have another concussion.

How do I know when it's ok to return to physical activity and my sport after a concussion? After telling your coach, your parents, and any medical personnel around that you think you have a concussion, you will probably be seen by a doctor trained in helping people with concussions. Your school and your parents can help you decide who is best to treat you and help to make the decision on when you should return to activity/play or practice. Your school will have a policy in place for how to treat concussions. You should not return to play or practice on the same day as your suspected concussion.

You should not have any symptoms at rest or during/after activity when you return to play, as this is a sign your brain has not recovered from the injury.

This information is provided to you by the UNC Matthew Gfeller Sport-Related TBI Research Center, North Carolina Medical Society, North Carolina Athletic Trainers' Association, Brain Injury Association of North Carolina, North Carolina Neuropsychological Society, and North Carolina High School Athletic Association.

Rev May 2016

Approved for use in 2018-19 School Year

Gfeller-Waller NCHSAA Student-Athlete & Parent/Legal Custodian Concussion Statement Form

Instructions: The student athlete and his/her parent or legal custodian, must initial beside each statement acknowledging that they have read and understand the corresponding statement. The student-athlete should initial in the left column and the parent or legal custodian should initial in the right column. Some statements are applicable only to the student-athlete and should only be initialed by the student-athlete. This form must be completed for each student-athlete, even if there are multiple student-athletes in the household.

Student-Athlete Name: (please print)_____

Parent/Legal Custodian Name(s): (please print)_____

Student-Athlete Initials		Parent/Legal Custodian(s) Initials
	A concussion is a brain injury, which should be reported to my parent(s) or legal custodian(s), my or my child's coach(es), or a medical professional if one is available.	
	A concussion cannot be "seen." Some signs and symptoms might be present immediately; however, other symptoms can appear hours or days after an injury.	
	I will tell my parents, my coach and/or a medical professional about my injuries and illnesses.	Not Applicable
	If I think a teammate has a concussion, I should tell my coach(es), parent(s)/ legal custodian(s) or medical professional about the concussion.	Not Applicable
	I, or my child, will not return to play in a game or practice if a hit to my, or my child's, head or body causes any concussion-related symptoms.	
	I, or my child, will need written permission from a medical professional trained in concussion management to return to play or practice after a concussion.	
	Based on the latest data, most concussions take days or weeks to get better. A concussion may not go away, right away. I realize that resolution from a concussion is a process that may require more than one medical visit.	
	I realize that ER/Urgent Care physicians will not provide clearance to return to play or practice, if seen immediately or shortly after the injury.	
	After a concussion, the brain needs time to heal. I understand that I or my child is much more likely to have another concussion or more serious brain injury if return to play or practice occurs before concussion symptoms go away.	
	Sometimes, repeat concussions can cause serious and long-lasting problems.	
	I have read the concussion symptoms listed on the Student-Athlete/ Parent Legal Custodian Concussion Information Sheet.	
	I have asked an adult and/or medical professional to explain any information contained in the Student-Athlete & Parent Concussion Statement Form or Information Sheet that I do not understand.	

By signing below, we agree that we have read and understand the information contained in the Student-Athlete & Parent/Legal Custodian Concussion Statement Form, and have initialed appropriately beside each statement.

_____ _____

Signature of Student-Athlete Date

_____ _____

Signature of Parent/Legal Custodian Date

HIGH SCHOOL FOOTBALL ONLY **GREEN FORM**

NOTICE AND RELEASE

IMPORTANT: **THIS NOTICE AND RELEASE MUST BE SIGNED AND RETURNED BEFORE YOUR STUDENT-ATHLETE CAN PARTICIPATE IN THE SENIOR HIGH FOOTBALL PROGRAM.**

To: Parents of students interested in participating in the Senior High Football Program

Subject: Student Accident Insurance – Senior High Football

Please read this Notice and Release carefully and make sure that you understand its provisions before deciding whether to permit your student-athlete to participate in the Senior High Football Program.

1. The Charlotte-Mecklenburg School System provides accident insurance in the amount of $50,000 at no charge for all students participating in the Senior High Football Program. **The Senior High Football accident insurance benefits provided by the school system will apply only towardthose covered expenses in excess of expenses recoverable from other insurance.** This means that any applicable personal insurance that you may carry would apply first, and the Senior High Football Accident Insurance would apply only to those covered expenses not paid by your other insurance. If you do not have other insurance, the Senior High Football Accident Insurance will pay toward covered expenses up to $50,000.

2. There are limitations under the Senior High Football Accident Insurance coverage. **It will not always pay all of the charges incurred for every accident.** This insurance only provides certain benefits for injury or loss due to practicing and playing in the Senior High Football program. For a summary of the coverage benefits, please refer to the Student Accident Insurance Information (for Senior High Football) that has been furnished to each student interested in participating in the Senior High Football Program. If you did not receive the information or if you have questions about the insurance coverage provided to participants in the Senior High Football Program, contact the Athletic Director/Coach where your student-athlete is enrolled.

3. Every player is required by the National Federation of State High School Athletic Associations (NFSHSAA) regulations to wear a mouth guard. An additional $300.00 per sound natural tooth is available for any player who sustains injuries to their teeth as a result of the failure of the mouth guard, provided that they were wearing the required mouth guard at the time of the injury.

PLEASE COMPLETE THE BACK OF THE FORM

HIGH SCHOOL FOOTBALL ONLY **GREEN FORM**

4. To be eligible for practice or participation in the Senior High Football Program, each participant must receive an **ANNUAL MEDICAL EXAMINATION** and return a physical examination form each calendar year (once every 365 days if signed before 1/1/2016 or once every 395 days if signed after 1/1/2016) signed by a physician licensed to practice medicine.

5. Neither the Board of Education nor any of its employees assumes any responsibility for claims resulting from injury to your Student Athlete while they are participating in the Senior High Football Program. This means that you will have to pay for any medical expenses not covered by the Senior High Football Accident Insurance, any personal insurance coverage that you might have and/or any other applicable insurance.

I, _____, (print name) hereby state that I have read and understand the provisions of this Notice and Release as well as the Student Accident Insurance information for the Senior High Football Accident Insurance coverage. I also state that prior to signing this document, I have had an opportunity to ask questions and that my questions have been answered to my satisfaction. I acknowledge that neither the Board of Education nor any of its employees assumes any responsibility for claims resulting from injury to my Student-Athlete while they are participating in the Senior High Football Program. In consideration of my Student-Athlete being permitted to participate in the Senior High Football Program, I **hereby waive, release, and forever discharge** the Charlotte-Mecklenburg Board of Education and its employees from any responsibility for claims resulting from injuries to my Student-Athlete due to their participation in the Senior High Football Program. I also state that my Student-Athlete has received a Medical Examination and has returned a physical examination form in compliance with the policy set forth in paragraph 4 of this Notice and Release. I certify that I consent to have my Student-Athlete participate in the Senior High Football Program offered at their school.

SIGNED: (Parent or Legal Guardian)_____ **Date** _____

Address: _____

Student's Full Name: _____

School: _____

I understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature and by typing my name above, I am electronically signing this document. 2017

ALL SPORTS EXCEPT FOOTBALL BLUE FORM

NOTICE AND RELEASE

IMPORTANT: **THIS NOTICE AND RELEASE MUST BE SIGNED AND RETURNED BEFORE YOUR SON/DAUGHTER CAN PARTICIPATE IN THIS PROGRAM.**

TO: Parents of students interested in participating in Athletics

SUBJECT: Student Accident Insurance for Athletics

SPORT (S): _____

Please read this Notice and Release carefully and make sure that you understand its provisions before deciding whether to permit your son or daughter to participate in middle or senior high athletics.

1. Board of Education policy requires that the Student Accident Insurance offered by the school system, will be required for all students participating in middle and senior high school athletics unless an insurance waiver form is signed by the parent indicating adequate personal insurance and releasing the Board of Education and its employees from responsibility for any claim due to injuries received while participating in a school sponsored athletic program.

2. There are limitations in the Student Accident Insurance coverage. **IT WILL NOT ALWAYS PAY ALL OF THE CHARGES INCURRED FOR EVERY ACCIDENT.** For a summary of the coverage and benefits provided by the Student Accident Insurance, please read the current Student Accident Insurance Brochure that was furnished to each student at the beginning of the school year. If you did not receive the brochure or if you have questions about the insurance coverage provided under the policy, contact the Athletic Director at the school where your son/daughter is enrolled.

3. To be eligible for practice or participation in any school athletic program, each participant must receive an **ANNUAL MEDICAL EXAMINATION** and return a physical examination form each calendar year (once every 365 days if signed before 1/1/2016 or once every 395 days if signed after 1/1/2016) signed by a physician licensed to practice medicine.

4. Neither the Board of Education nor any of its employees assumes any responsibility for claims resulting from injury to your son/daughter while he or she is participating in the school athletic program. This means that you will have to pay for any medical expenses not covered by the Student Accident Insurance, any personal insurance coverage that you might have and/or any other applicable insurance.

ALL SPORTS EXCEPT FOOTBALL BLUE FORM

PLEASE COMPLETE THE BACK OF THE FORM

I, _____, (print name) hereby state that I have read and understand the provisions of this Notice and Release as well as the Student Accident Insurance Brochure. I further state that prior to signing this document, I have had an opportunity to ask questions and that my questions have been answered to my satisfaction. I acknowledge that neither the Board of Education nor any of its employees assumes any responsibility for claims resulting from injury to my son/daughter while he or she is participating in the school athletic program. **I HEREBY WAIVE, RELEASE, AND DISCHARGE** the Charlotte-Mecklenburg Board of Education and its employees from any responsibility for claims resulting from injuries to my son/daughter due to his or her participation in this athletic program. I hereby certify that my son/daughter has received a MEDICAL EXAMINATION and has returned a physical examination form in compliance with the policy set forth in paragraph 3 of this Notice and Release. I certify that I consent to have my son/daughter participate in school athletic activity as identified on this Notice and Release. I make the following representation and selection (check one, sign and return promptly):

_____ I have adequate personal insurance that will cover injuries that might be sustained by my son/daughter as a result of his/her participation in the school athletics. I understand that in the event my son/daughter sustains any injuries as a result of his/her participation in school athletics, I am responsible for payment of medical expenses or other items not covered by any personal insurance.

_____ My son/daughter has enrolled in the Student Accident Insurance Program on _____/_____/_____, and I understand that in the event my son/daughter sustains any injuries as a result of his/her participation in school athletics, I am responsible for payment of any medical expenses or other items not covered by the Student Accident Insurance.

SIGNED: (Parent or Legal Guardian)_____ **Date** _____

ADDRESS: _____

STUDENT'S FULL NAME: _____

SCHOOL: _____

2018-2019 NCHSAA ELIGIBILITY, CONSENT TO PARTICIPATE AND RELEASE FORM

THIS DOCUMENT MUST BE SIGNED BY THE STUDENT-ATHLETE OF AN NCHSAA MEMBER SCHOOL AND BY THE STUDENT'S PARENT OR LEGAL CUSTODIAN BEFORE PARTICIPATION. STUDENTS MAY NOT PARTICIPATE WITHOUT THE SIGNATURE OF THE STUDENT AND PARENT(S)/LEGAL CUSTODIAN.

I have read, understand and acknowledge receipt of the North Carolina High School Athletic Association's Eligibility Rules. I understand that a copy of the NCHSAA Handbook is on file with the member school's principal and/or Athletic Director, and that I may review it, in its entirety if I so choose. I know my school is a member of the NCHSAA and must adhere to all regulations that govern interscholastic athletic programs, including, but not limited to, Federal and State laws, local regulations and those imposed by the NCHSAA. I understand that local rules may be more stringent than the NCHSAA and agree to follow the rules of my school and the NCHSAA and to abide by their decisions. I acknowledge and understand that participation in interscholastic athletics is a privilege, not a right. I understand that classroom performance, dropping a class or taking coursework through other educational options could affect eligibility and compliance with NCHSAA academic standards.

STUDENT CODE OF RESPONSIBILITY

As a student athlete, I **understand and accept** the following responsibilities:

I will **respect the rights and beliefs** of others and will treat others with courtesy and consideration.
I will be **fully responsible** for my own actions and the consequences of my actions.
I will **respect the property** of others.
I will **respect and obey the rules** of my school and laws of my community, state and country.
I will **show respect to those who are responsible for enforcing the rules** of my school and the laws of my community, state and country.
I **understand that a student whose character or conduct violates** the school's Athletic Code or School Code of Responsibility could be deemed ineligible for a period of time as determined by the principal or school system Administration

PARENTS, LEGAL CUSTODIANS OR STUDENTS WHO DO NOT WISH TO ACCEPT THE RISK DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS FORM. The student and parent/legal custodian recognize that participation in interscholastic athletics involves some inherent risks for potentially severe injuries including, but not limited to, serious neck, head and spinal injuries, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the musculoskeletal system, serious injury or impairment to other aspects of the body, or effects to the general health and well-being of the child, and in rare cases death. Although serious injuries are not common in supervised school athletic programs, it is impossible to eliminate all risk. Because of these inherent risks, the student and his/her parent/legal custodian have a responsibility to help reduce that risk. Participants must obey all safety rules, report all physical and hygiene problems to their coaches, follow a proper conditioning program, and inspect their own equipment daily.

I authorize medical treatment should the need arise for such treatment while I or my child/ward ("student-athlete") is under the supervision of the member school. I **consent to medical treatment** for the student-athlete following an injury or illness suffered during practice and/or a contest. I understand that in the case of **injury or illness requiring treatment by medical personnel and transportation to a health care facility**, a reasonable attempt will be made to contact the parent/legal custodian in the case of the student-athlete being a minor, but that, if necessary, the student-athlete will be treated and transported via ambulance to the nearest hospital. I further authorize the use or disclosure of my student-athlete's personally identifiable health information should treatment for illness or injury become necessary.

I **understand all concussions are potentially serious** and may result in complications including prolonged brain damage and death if not recognized and managed properly. Further, I understand that if my student is removed from a practice or competition due to a suspected concussion, he or she will be unable to return to participation that day. After that day, written authorization from a physician (M.D. or D.O.) or an athletic trainer working under the supervision of a physician will be required before the student is allowed to return to participation. I also acknowledge that I **have received, read and signed** the **Gfeller-Waller Concussion Information Sheet.**

I **consent to the NCHSAA's use of the herein named student's name**, likeness, and athletic-related information in reports of contests, promotional literature of the Association and other materials and releases related to interscholastic athletics and grant the NCHSAA the right to photograph and/or videotape the participant and further to use the participant's face, likeness, voice and appearance in connection with exhibitions, publicity, advertising, promotional and commercial materials without reservation or limitation. The NCHSAA, however, is under no obligation to exercise said rights herein. I further consent to the disclosure, by the member school, to the NCHSAA, upon its request, of all records relevant to the student-athlete's athletic eligibility including, but not limited to, their records relating to enrollment, attendance, academic standing, age, discipline, finances, residence and physical fitness. The student and parent/legal custodian individually and on behalf of the student, hereby irrevocably, and unconditionally release, acquit, and discharge, without limitation, the NCHSAA its officers, agents, attorneys, representatives and employees (collectively, the "Releasees") from any and all losses, claims, demands, actions and causes of action, obligations, damages, and costs or expenses of any nature (including attorney's fees) that the student and/or legal custodian incur or sustain to person, property or both, which arise out of, result from, occur during or are otherwise connected with the student's participation in interscholastic athletics if due to the ordinary negligence of the Releasees.

By signing this document, we acknowledge that we have read the above information and that we consent to participation by the herein named student. We understand that the authorizations and rights granted herein are voluntary and that we may revoke any or all of them at any time by submitting said revocation in writing to the participant's member school. By doing so, however, we understand that the participant would no longer be eligible for participation in interscholastic athletics.

_____

Student's Signature | Date of Birth | Grade in School | Date

_____

Signature of Parent or Legal Custodian | Date

Revised May 2018

Student-Athlete & Parent/Guardian
Confirmation of Signed Athletic Eligibility Forms

My signature below confirms I read, understand and completed in full the on-line athletic eligibility forms noted below. In addition, I emailed the documents _____
(file name)

to _____ on _____.
(school athletic director) *(date)*

My signature also confirms the information I provided on all athletic eligibility forms is accurate and truthful. I understand false and/or inaccurate information may result in a 365-day athletic ineligibility period for the student-athlete who signs below. **I understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature and by typing my name in the packet; I am electronically signing those documents.**

Student-Athlete Signature _____ Date _____

Print Name _____

Parent/Guardian Signature _____ Date _____

Print Name _____

Athletic Forms Package

(Initial all forms submitted or printed)

____ CMS High School Eligibility Form

____ CMS High School Pre-Participation Form

____ Athletic Honor Code Form Student/Parent

____ Concussion Statement Student/Parent

____ 2018-19 Football Insurance-Green Form

____ 2018-19 All Other Sports Insurance-Blue Form

____ NCHSAA Eligibility and Authorization Form

____ Confirmation of Signed Eligibility Forms
(Print & complete this form and hand deliver to AD)

____ NCHSAA HS Pre-Participation Exam Form
(Print form and hand deliver to AD after physician signs)

____ 2018-19 CMC Medical Release of Information-Student
(Print & complete this form and hand deliver to AD)

____ 2018-19 CMS Medical Release of Information in Spanish
(Print & complete this form and hand deliver to AD)

____ Athletic Participation Fee Waiver Application (if Applicable)
(Print & complete this form and hand deliver to AD)

NORTH CAROLINA HIGH SCHOOL ATHLETIC ASSOCIATION SPORT PREPARTICIPATION EXAMINATION FORM

Student Athlete's Name: _____ Age: _____ Sex: _____

This is a screening examination for participation in sports. <u>This does not substitute for a comprehensive</u> <u>examination</u> with your child's regular physician where important preventive health information can be covered.

<u>Student-Athlete's Directions:</u> Please review all questions with your parent or legal custodian and answer them to the best of your knowledge.
<u>Parent/Legal Custodian Directions:</u> Please assure that all questions are answered to the best of your knowledge. If you do not understand or are unsure about the answer to a question please ask your doctor. Not disclosing accurate information may put your child at risk during sports activity.
<u>Physician's Directions:</u> We recommend carefully reviewing these questions and clarifying any "Yes" or "Unsure" answers.

Explain "Yes" or "Unsure" answers in the space provided below or on an attached separate sheet if needed.	Yes	No	Unsure
1. Does the student-athlete have any chronic medical illnesses [diabetes, asthma (exercise asthma), kidney problems, etc.]? List:	❑	❑	❑
2. Is the student-athlete presently taking any medications or pills?	❑	❑	❑
3. Does the student-athlete have any allergies (medicine, bees or other stinging insects, latex)?	❑	❑	❑
4. Does the student-athlete have the sickle cell trait?	❑	❑	❑
5. Has the student-athlete ever had a head injury, been knocked out, or had a concussion?	❑	❑	❑
6. Has the student-athlete ever had a heat injury (heat stroke) or severe muscle cramps with activities?	❑	❑	❑
7. Has the student-athlete ever passed out or nearly passed out DURING exercise, emotion or startle?	❑	❑	❑
8. Has the student-athlete ever fainted or passed out AFTER exercise?	❑	❑	❑
9. Has the student-athlete had extreme fatigue (been really tired) with exercise (different from other children)?	❑	❑	❑
10. Has the student-athlete ever had trouble breathing during exercise, or a cough with exercise?	❑	❑	❑
11. Has the student-athlete ever been diagnosed with exercise-induced asthma?	❑	❑	❑
12. Has a doctor ever told the student-athlete that they have high blood pressure?	❑	❑	❑
13. Has a doctor ever told the student-athlete that they have a heart infection?	❑	❑	❑
14. Has a doctor ever ordered an EKG or other test for the student-athlete's heart, or has the athlete ever been told they have a heart murmur?	❑	❑	❑
15. Has the student-athlete ever had discomfort, pain, or pressure in his chest during or after exercise or complained of their heart "racing" or "skipping beats"?	❑	❑	❑
16. Has the student-athlete ever had a seizure or been diagnosed with an unexplained seizure problem?	❑	❑	❑
17. Has the student-athlete ever had a stinger, burner or pinched nerve?	❑	❑	❑
18. Has the student-athlete ever had any problems with their eyes or vision?	❑	❑	❑
19. Place a check beside each body part that the student-athlete has ever sprained/strained, dislocated, fractured, broken had repeated swelling in or had any other type of injury to any bones or joints? ❑ Head ❑ Shoulder ❑ Thigh ❑ Neck ❑ Elbow ❑ Knee ❑ Chest ❑ Hip ❑ Forearm ❑ Shin/calf ❑ Back ❑ Wrist ❑ Ankle ❑ Hand ❑ Foot Other: _____			
20. Has the student-athlete ever had an eating disorder, or are there concerns about his/her eating habits or weight?	❑	❑	❑
21. Has the student-athlete ever been hospitalized or had surgery?	❑	❑	❑
22. Has the student-athlete had a medical problem or injury since their last evaluation?	❑	❑	❑
23. (Place a check beside each statement that applies to the student-athlete, elaborate in the space provided below). ❑ 1. Has the student-athlete had little interest or pleasure in doing things? ❑ 2. Has the student-athlete been feeling down, depressed, or hopeless for more than 2 weeks in a row? ❑ 3. Has the student-athlete been feeling bad about himself/herself that they are a failure, or let their family down? ❑ 4. Has the student-athlete had thoughts that he/she would be better off dead or hurting themselves?			
FAMILY HISTORY			
24. Has any family member had a sudden, unexpected death before age 50 (including from sudden infant death syndrome [SIDS], car accident, drowning)?	❑	❑	❑
25. Has any family member had unexplained heart attacks, fainting or seizures?	❑	❑	❑
26. Does the athlete have a father, mother or brother with sickle cell disease?	❑	❑	❑

Explain "yes" or "unsure" answers here: _____

_____

By signing below, I agree that I have reviewed and answered each question above. Every question is answered completely and is correct to the best of my knowledge. Furthermore, as parent or legal custodian, I give consent for this examination and give permission for my child to participate in sports.

Signature of parent/legal custodian: _____ Date: _____ Phone #: _____

Signature of Athlete: _____ Date: _____

Student-Athlete's Name: _____**Age:** _____ **Date of Birth:** _____

Height: _____ **Weight:** _____ **BP**_____(____% ile) /_____(____% ile) **Pulse:** _____

Vision: R 20/_____**L 20/**_____**Corrected: Y N**

Physical Examination (Below Must be Completed by Licensed Physician, Nurse Practitioner or Physician Assistant)

These are required elements for all examinations			
	NORMAL	ABNORMAL	ABNORMAL FINDINGS
PULSES			
HEART			
LUNGS			
SKIN			
NECK/BACK			
SHOULDER			
KNEE			
ANKLE/FOOT			
Other Orthopedic Problems			

Optional Examination Elements – Should be done if history indicates

HEENT			
ABDOMINAL			
GENITALIA (MALES)			
HERNIA (MALES)			

Clearance:

- ❑ **A. Cleared**
- ❑ **B. Cleared after completing evaluation/rehabilitation for:** _____
- ❑ ***** C. Medical Waiver Form must be attached (for the condition of:** _____**)**
- ❑ **D. Not cleared for:** ❑ **Collision** ❑ **Contact** ❑ **Non-contact**

_____**Strenuous**_____**Moderately strenuous**_____**Non-strenuous**

Due to: _____

_____

_____

Additional Recommendations/Rehab Instructions: _____

_____

_____

Name of Physician/Extender: _____ (Please print)

Signature of Physician/Extender: _____ MD DO PA NP (Please circle)

(Both signature and circle of designated degree required)

Date of Examination: _____

Address: _____

_____

Phone: _____

Physician Office Stamp

(*** The following are considered disqualifying until appropriate medical and parental releases are obtained: post-operative clearance, acute infections, obvious growth retardation, uncontrolled diabetes, severe visual or auditory impairment, pulmonary insufficiency, organic heart disease or Stage 2 hypertension, enlarged liver or spleen, a chronic musculoskeletal condition that limits ability for safe exercise/sport (i.e. Klippel-Feil anomaly, Sprengel's deformity), history of uncontrolled seizures, absence of/ or one kidney, eye, testicle or ovary, etc.)

Carolinas HealthCare System

REQUEST FOR TREATMENT AND AUTHORIZATION FORM

REQUEST FOR TREATMENT. The Hospital maintains personnel and facilities to assist my physicians in providing me medical care, and I authorize the Hospital personnel to perform on me the care ordered by my physicians. I understand that I have the right to be informed by my physicians of the nature and purpose of any proposed operation or procedure and any available alternative methods of treatment, together with an explanation of the risks associated with each of them. This form is not a substitute for such explanations, which are the responsibility of my physicians to provide according to recognized standards of medical practice, and I acknowledge that the Hospital and its personnel are not responsible for providing me this information. I consent to receive services by telemedicine (using interactive audio, video, or data communications to carry out consultations, evaluations, screenings, diagnosis, treatment, monitoring, or other communications benefiting a patient) if appropriate for my condition, and I understand the risks, benefits and alternatives of doing so.

I authorize the Hospital and my physicians/athletic trainers to take pictures and/or video of me for treatment and health care operation purposes.

I have read the foregoing request and authorization in its entirety and agree to be bound by all terms and conditions herein. Witness my (our) hand(s) below.

_____ _____

Patient Name Printed Responsible Party/ies Parent/Guardian Signature

_____

Date

_____

Witness

_____

I have been provided access to CHS's Notice of Privacy Practices

Signature _____ Date:_____ Time: _____

(Patient or Authorized Representative)

Relationship to Patient:_____

Reason Patient Unable/Unwilling to sign_____

Patient Information: I give permission to release the health information of: **(One Patient Per Form)**

Patient Name: _____ Date of Birth: _____

Street Address: _____ Last 4 numbers of SSN:_____

City, State, Zip: _____ Telephone: ( ) _____

Email address: _____

Release Information From:
Carolinas Healthcare System

_____
(List applicable Facility(s) and/or Practice(s)

_____

_____
(Phone number) (Fax number)

Release Information To:
Charlotte-Mecklenburg Schools

_____
(Name of facility, person, company) (Relationship)

PO Box 30035 Charlotte, NC 28230-0035

_____
(Street Address or PO Box, City, State, Zip Code)

980-343-6980

_____
(Phone number) (Fax number)

PURPOSE OF RELEASE (check reason): ☐ Request of individual/personal ☐ Continued patient care ☐ Insurance
☐ Legal purpose including discussions & proceedings X Other Sports Medicine including oral & written communication

Fill in dates of treatment for records to be released:
Treatment dates: From Aug 1, 2018 **To** July 31, 2019
Hospital Summary: May include history & physical, discharge summary, operative notes, consults, diagnostic test results, medication list, allergies.
Office/Clinic Summary: May include most recent office visits, physical exam, consults, diagnostic test results.

Hospital (check all that may apply):
☐ Hospital Summary
☐ Discharge Summary ☐ Emergency Record
☐ History and Physical ☐ Cardiac Reports/EKG
☐ Consultation reports ☐ Other_____
☐ Operative Reports _____
☐ Laboratory reports _____
☐ Radiology/X-Ray Reports _____
☐ Pathology reports _____

☐ Entire record (Not including psychotherapy notes)

Office/Clinic (check all that may apply):
☐ Office/Clinic Summary
☐ Office Visits
X Physical Exam
X Laboratory Reports
X Radiology Reports
X Other Research Participation
X ATC Medical Records

☐ Entire Record (Not including psychotherapy notes)

Behavioral Health/Sub. Abuse (check all that may apply):
☐ Hospital Summary
☐ Assessments
☐ Discharge Summary
☐ Physician Orders
☐ Progress notes
☐ Medications
☐ Lab reports
☐ Other _____

☐ Entire Record (Not including psychotherapy notes)

FORMAT:
☐ CD (charges may apply)
☐ Email Address noted above, where permitted
☐ Paper copy (charges may apply)
☐ Other_____

DELIVERY METHOD:
☐ Reg.US Mail ☐ Pick-up ☐ Fax, where permitted
☐ Overnight/Express Mail Service, where permitted
☐ Secure email
☐ Other: _____

PATIENT'S RIGHTS – I understand that:

- **I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice.**
- **This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases.**
- **Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.**
- **Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits.**
- **CHS will not share or use my health information without my permission other than by ways listed in CHS's Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at carolinashealthcare.org.**
- **A fee may be charged for providing the protected health information.**
- **I have a right to receive a copy of this form upon request.**

This permission expires one year after the date of my signature unless another date or event is written here: _____

Signature: _____ **Print Name:** _____ **Date:**_____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form.
Note the relationship/authority if signature is not that of the patient (Written Proof May be Requested):
☐ **Healthcare Agent/POA** ☐ **Guardian** ☐ **Executor/Administrator/Attorney in Fact** ☐ **Spouse**
☐ **Parent** ☐ **Adult Child** ☐ **Affidavit Next of Kin** ☐ **Other:** _____

Note: If minor consented for their outpatient treatment for pregnancy, sexually transmitted disease or behavioral/mental health without parental consent, the minor must sign this authorization. When the patient is a minor being treated for substance abuse, the minor must sign this authorization, regardless of who consented for treatment.

Signature of Minor:_____ **Print Name:** _____ **Date:** _____

Authorization given to patient / Date of release:_____via ☐Mail ☐Fax ☐Other_____ ☐**ID Verified** ☐**DL/Other ID**_____
CHS Employee Name & Title: _____ **CHS Employee Signature:** _____ **Date:**_____

905

Carolinas HealthCare System
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Information or Sticker
Name:
DOB:
Medical Record #:
Account #:

Información del Paciente: Yo doy permiso para revelar la información de salud de: (Un paciente por formulario)

Nombre del paciente: _____ Fecha de Nacimiento: _____

Dirección: _____ 4 últimos números del SS: _____

Ciudad, Estado, Código postal: _____ Teléfono: _____

Dirección de correo electrónico: _____

Revelar información de:	Revelar información a:
_____ (Indique Institución (es) y / o Consultorio (s) pertinente (s))	_____ (Nombre de la institución, persona, empresa) (Relación)
_____	_____ (Dirección o Apartado Postal / PO Box, Estado, Código Postal)
_____ (Número de teléfono)	_____ (Número de teléfono) (Número de fax)

PROPÓSITO DE LA ENTREGA (marque razón): ☐ Solicitud individual/ personal ☐ Atención continua al paciente ☐ Seguros
☐ Propósito legal, incluidos debates y procesos ☐ Otro _____

Indicar las fechas de tratamiento del historial médico a ser entregado:
Fechas de tratamiento: Desde 1 Ago, 2015 _____ hasta 31 Julio, 2016
Resumen del Hospital: Puede incluir historial y físicos, informe de alta, notas quirúrgicas, consultas, resultados de pruebas de diagnóstico, lista de medicamentos, alergias.
Resumen de Consultorio / Clínica: Puede incluir visitas más recientes al consultorio, examen físico, consultas, resultados de pruebas diagnósticas.

Hospital (marque todas las que apliquen):	Consultorio / Clínica (marque todas las que apliquen):	Salud Mental/ Abuso Sub. (marque todas las que apliquen):
☐ Resumen de Hospital	☐ Resumen de Consultorio/Clínica	☐ Resumen de Hospital
☐ Resumen de alta ☐ Reportes de Emergencias	☐ Visitas de Consultorio	☐ Evaluaciones
☐ Historial y Físico ☐ Reportes cardíacos /	☐ Examen Físico	☐ Resumen de alta
☐ Informes de Consulta electrocardiogramas	☐ Informes de laboratorio	☐ Órdenes médicas
☐ Informes operativos ☐ Otro _____	☐ Informes de Radiología	☐ Notas de progreso
☐ Informes de laboratorio _____	☐ Otro _____	☐ Medicamentos
☐ Informes de Radiología / Rayos X _____	_____	☐ Informes de laboratorio
☐ Informes de patología _____	☐ Expediente completo (No incluye notas de psicoterapia)	☐ Otro _____
☐ Expediente completo (No incluye notas de psicoterapia)		_____
		☐ Expediente completo (No incluye notas de psicoterapia)

FORMATO:	MÉTODO DE ENTREGA:
☐ CD (cargo puede aplicar)	☐ Correo Reg. ☐ Recogido ☐ Fax, cuando lo permita
☐ Correo electrónico indicado anteriormente, cuando lo permita	☐ Email seguro ☐ Servicio de correo Nocturno / urgente, cuando permita
☐ Copia en papel (cargo puede aplicar) ☐ Otro _____	☐ Otro: _____

DERECHOS DEL PACIENTE - Entiendo que:

- Puedo cancelar este permiso en cualquier momento. Tengo que cancelar por escrito y enviar o entregar la cancelación a la instalación o consultorio que revela nombrado arriba. En caso de cancelación aplicará únicamente a la información aún no publicada por dicha instalación o consultorio.
- Esta es una revelación completa, incluyendo información relacionada con el tratamiento de comportamiento / salud mental, del abuso de drogas y alcohol (en cumplimiento con el 42 CFR Parte 2), información genética, VIH / SIDA y otras enfermedades de transmisión sexual.
- Una vez que se entrega mi información de salud, el destinatario puede revelar o compartir mi información con otras personas y mi información puede no estar protegida por las protecciones federales y estatales de privacidad.
- El negarme a firmar este formulario no impedirá mi habilidad para obtener tratamiento, pago, inscripción en el plan de salud o calificar para beneficios.
- CHS no compartirá ni usará mi información médica sin mi permiso que no sea de la forma que figura en el Anuncio de Prácticas de Privacidad de CHS o de lo requerido por la ley. El Anuncio de Prácticas de Privacidad está disponible en carolinashealthcare.org.
- Un cargo puede ser aplicado por proporcionar la información de salud protegida.
- Tengo derecho a recibir una copia de este formulario a petición.

Este permiso se vence un año después de la fecha de mi firma a menos que otra fecha o evento se escriba aquí: _____

Firma: _____ Nombre en letra de imprenta: _____ Fecha: _____

Nota: Si el paciente carece de capacidad legal o no puede firmar, un representante personal autorizado puede firmar este formulario.
Anote la relación / autoridad si la firma no es la del paciente (Prueba escrita puede ser solicitada):
☐ Agente de Salud / Poder Notarial ☐ Tutor ☐ Ejecutor / Administrador / Apoderado ☐ Cónyuge
☐ Padre/Madre ☐ Hijo Adulto ☐ Pariente más cercano por declaración jurada ☐ Otro: _____

Nota: Si el menor de edad consintió para su tratamiento ambulatorio para embarazo, enfermedades de transmisión sexual o salud del comportamiento / mental sin consentimiento de los padres, el menor deberá firmar esta autorización. Cuando el paciente es un menor de edad que recibe tratamiento para el abuso de sustancias, el menor debe firmar esta autorización, independientemente de quién consintió para el tratamiento.

Firma del menor: _____ Nombre en letra de imprenta: _____ Fecha: _____

Autorización dada al paciente / Fecha de relevo:_____vía ☐Correo ☐Fax ☐Otro_____ ☐Identificación verificada ☐Licencia de Conducir u Otra
(Authorization given to patient / Date of release) (via Mail) (Other) (ID Verification DL/Other ID)

CHS Employee Name & Title: _____ **CHS Employee Signature:** _____ **Date**_____

Carolinas HealthCare System
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION
Spanish

Patient Information or Sticker

Name:
DOB:
Medical Record #:
Account #:

Charlotte-Mecklenburg Schools
Application for Waiver of Athletic Participation Fee

In June 2010, the Board of Education initially approved participation fees for middle and high school athletic participation. In July 2017 participation fees were adjusted. Middle school students pay a fee of $75 and high school students pay a fee of $125 for each interscholastic sports season in which they participate on one or more teams. Payment of this fee is required by a deadline which is established for each sports season.

In June 2014, the Board of Education approved CMS to participate in the federal Community Eligibility Provision (CEP). The CEP eliminates the need for a district to qualify students for free and reduced price meals and track which students are participating. Students are identified as directly certified (through data matching) for free meals because they live in households that participate in Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TNAF), or Food Distribution Program on Indian Reservations (FDPIR), as well as children who are qualified for free schools meals without submitting a school meal application because of their status as being in foster care, enrolled in Head Start, homeless, runaway, or migrant students.

A student-athlete who is directly certified automatically qualifies for a participation fee waiver. A directly certified student-athlete must provide a copy of their notification letter from CMS Child Nutrition confirming their status.

A student who attends a CEP school but is not directly certified may, if they qualify, complete the Application for Need Based Assistance form accompanied by proof of total household income (pay stub, tax return, etc.). The Application for Need Based Assistance form serves in place of the free and reduced lunch approval letter.

A student who attends a non-CEP school and is not directly certified may apply for free and reduced lunch status (FRL). A student at a non-CEP school who is approved for FRL will have their participation fee waived. A family will receive a notification letter from CMS Child Nutrition if their child is approved for free and reduced lunch. Waiver process changes

---

If you wish to apply for a fee waiver, please fill out the information below and return this form to your child's athletic director or athletic coach.
Partially completed forms will not be accepted.
A separate form must be filled out for each student-athlete for whom a waiver is requested.

Name of student _____ [please print]

Student ID number _____ [please print]

School _____ [please print]

Parent/guardian name _____ [please print]

Address _____ _____ [please print]
Number/Street City, State

I hereby apply for a waiver of the CMS athletic participation fee and affirm the information provided on and with this application is accurate.

_____
Parent/Guardian (Print Name)

_____ _____
Parent/guardian signature Date