

High Point Christian Academy

Athletic Participation Form

This form is to be filled out completely and filed in the office **before** the student can participate in the school athletic programs.

Student _____
First Middle Last

Grade _____ Sports to participate _____

Student Address _____

City _____ State _____ Zip _____ Phone _____

Parents' Name _____ Work/Cell Phone _____

Emergency Contact _____ Phone _____

Family Physician _____ Address _____

Medical History

Student _____ Birthdate _____ Age _____

Is there a known history of:

- | | | |
|--|---|---|
| A. Birth deformities (one eye, one kidney, etc.)? | Y | N |
| B. Known past illness of more than one week's duration | Y | N |
| C. Medical conditions currently under treatment? | Y | N |
| D. Fractures or other disabling injuries? | Y | N |
| E. Any permanent deformity or disability? | Y | N |
| F. Allergy (drugs, food, clothing, etc.)? | Y | N |
| G. Mental disorder or convulsions? | Y | N |

Explain any above questions answered "yes": _____

Parental Permission

As parent or legal guardian of _____, I hereby give my consent for his/her practice and play in the athletic event(s) listed above. I also grant permission for treatment deemed necessary for conditions 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.

Parent Signature

Date

Examination

Date of Examination: _____

Height _____

Weight _____

Blood Pressure _____

	Normal	Abnormal	Describe Abnormalities
Eyes	_____	_____	_____
ENT	_____	_____	_____
Heart	_____	_____	_____
Lungs	_____	_____	_____
Abdomen	_____	_____	_____
Genitals (Males)	_____	_____	_____
Musculoskeletal	_____	_____	_____
Neurological	_____	_____	_____
Skin	_____	_____	_____

Laboratory

Urinalysis: _____

Other: _____

I certify that I have examined this student and find him/her medically (qualified, not qualified) to compete in interscholastic sports.

Licensed to practice medicine in N C.? Yes _____ No _____

Physician's Signature: _____ Date _____

Address _____

If student not qualified, list reasons for disqualification: _____
