



CROSSROADS CHRISTIAN SCHOOL

Athletic Permission Form

This medical examination and form must be completed annually and be on file prior to any athletic practice or competition.

Student Information (to be completed by student/parents):

Name of Student _____ Date: _____ Grade: _____

Student's Address: _____
Street City State Zip

Parent's Name: _____ Phone: _____

Family Physician: _____ Phone: _____

Physician's Address: _____
Street City State Zip

I hereby apply for permission to participate in the following interscholastic sports:

I certify that the information contained in this application is correct, and I agree to abide by the eligibility rules and regulations of the State Association.

Student Signature _____ Date _____

Medical History (to be completed by parents):

Student Date of Birth: _____ Current Age of Student: _____

Is there a known history of any of the following?

- | | | |
|---|------------------------------|-----------------------------|
| 1. Birth deformities (one eye, one kidney, etc.)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Known past illness of more than one week's duration? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Medical conditions currently under treatment? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Fractures or other disabling injuries? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Any permanent deformity or disability? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Allergy (drugs, food, clothing, etc.)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Mental disorder or convulsions? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Explain any above questions answered with a "Yes":

Parental Permission:

As parent or legal guardian of _____, I hereby give my consent for him/her to practice and play in the athletics 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 below is accurate to the best of my knowledge.

Parent Signature _____ Telephone Number _____ Date _____



Athletic Medical Examination for

Student Name

Height _____ Weight _____ Blood Pressure: _____

Normal?

- _____ 1. Eyes
- _____ 2. ENT
- _____ 3. Heart
- _____ 4. Lungs
- _____ 5. Abdomen
- _____ 6. Genitalia (males only)
- _____ 7. Musculoskeletal
- _____ 8. Neurological
- _____ 9. Skin

Laboratory:

Urinalysis:

Other (where indicated)?

Physician's Certification:

I certify that I have examined this student and find him/her medically

- Qualified
- Not qualified

to compete in the interscholastic sport(s) listed above.

If student is not qualified, list reasons for disqualifications:

Are you licensed to practice medicine in North Carolina? Yes No

Physician Name (print)

Physician Signature & DEA#

Date