



CROSSROADS CHRISTIAN SCHOOL

Athletic Permission Form

This two-page 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