

School year \_\_\_\_\_



**Athletic Participation Form**

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Gender \_\_\_\_\_ Grade \_\_\_\_\_

**Please list parent/guardian names in the order which you would like to be called in an emergency.**

Parent/Guardian's Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone: Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Parent/Guardian's Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone: Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

**If for any reason, I/we cannot be reached, please contact the following person(s) whom I/we hereby authorize to seek emergency medical or surgical care for my/our child.**

Name \_\_\_\_\_ Phone: Cell \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_

Name \_\_\_\_\_ Phone: Cell \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_

**EMERGENCY MEDICAL TREATMENT PERMISSION AND INFORMATION**

I/We hereby authorize the school to obtain, through a physician of its own choice, any emergency care that may become reasonably necessary for the student in the course of athletic activities or travel. I/We, or the insurance company providing coverage for above named student, guarantee payment of all charges incurred for medical treatment. I also give consent for the athletic trainer/coach to administer pain relievers if necessary.

**INSURANCE:** As the parent/guardian of the above named student I understand that the school's insurance that is furnished as part of the registration fee, will serve as a secondary insurance to any policy I may have. In the event that I do not have insurance, the school's policy will serve as the primary policy.

\_\_\_\_\_ My child's **Medical Information** is current in Renweb.  
**(Please list in Renweb all medical conditions, food and/or medicine allergies, etc.)**

\_\_\_\_\_ My child's **Medical Insurance** is current in Renweb

**AUTHORIZATION FOR PARTICIPATION IN INTERSCHOLASTIC ATHLETICS**

I/We certify that all information in this application is correct and I agree to abide by the eligibility rules and regulations governing athletics as set forth by the Association in which Northside Christian Academy is a member

Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

**THIS SECTION TO BE COMPLETED BY PHYSICIAN  
HEALTH EXAMINATION**

**AGE:** \_\_\_\_\_ **HEIGHT:** \_\_\_\_\_ **WEIGHT:** \_\_\_\_\_ **B/P:** \_\_\_\_\_ **VISUAL:** \_\_\_\_\_

**CARDIOVASCULAR:** \_\_\_\_\_ **ABDOMEN:** \_\_\_\_\_ **MUSCULO-SKELETAL** \_\_\_\_\_

**NEUROLOGICAL:** \_\_\_\_\_ **SKIN:** \_\_\_\_\_ **LIVER:** \_\_\_\_\_ **HERNIA** \_\_\_\_\_

**URINALYSIS:** \_\_\_\_\_ **SCOLIOSIS:** \_\_\_\_\_ **OTHER:** \_\_\_\_\_

**SIGNATURE OF EXAMINING PHYSICIAN** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
**(Physical expires one year from date)**

**ADDRESS OF PHYSICIAN:** \_\_\_\_\_

**LICENSED TO PRACTICE MEDICINE IN NORTH CAROLINA? YES NO**