

Parental Permission and Medical Examination Form

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

Student _____
School _____ Grade _____ Date _____
Address of Student _____
City _____ State _____ Zip _____
Parent's Names _____ Telephone Number _____
Family Physician _____ Address _____

I certify that the information in the application is correct and I agree to abide by the eligibility rules and regulations governing athletics as set forth by the North Carolina State Board of Education and the Associations to which my school is a member.

Signature of Student _____

Medical History (To be completed by parents)

Student _____ Age _____ Grade _____

Is there a known history of:

- | | | |
|---|-----------|----------|
| A. Birth deformities (one eye, one kidney, etc.)? | Yes _____ | No _____ |
| B. Known past illness of more than one week's duration? | Yes _____ | No _____ |
| C. Medical conditions currently under treatment? | Yes _____ | No _____ |
| D. Fractures or other disabling injuries? | Yes _____ | No _____ |
| E. Any permanent deformity or disability? | Yes _____ | No _____ |
| F. Allergies (drugs, food, clothing, etc.)? | Yes _____ | No _____ |
| G. Mental disorder or convulsions? | Yes _____ | No _____ |

Explain any questions answered "yes":

Insurance

School policy requires that all students who participate in interscholastic athletics be adequately covered by accident insurance.

I certify that I have purchased and/or I will maintain in full force and effect an accident insurance policy on my child, as follows:

____ School Insurance, or
____ Other, Name of Company _____
Address _____
Policy Number _____ Date _____

If the policy is canceled for any reason, I agree to notify the school within five days.

Signature of Parent/Guardian _____

Parental Permission

As parent or legal guardian of _____, I hereby give my consent for his/her practice and play in athletics events.

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 is accurate to the best of my knowledge.

Signature of Parent/Guardian _____

Student _____

Examination

Height _____ Weight _____ Blood Pressure _____

	NORMAL	ABNORMAL	DESCRIBE ABNORMALITIES
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) _____

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

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

Signature _____

Address _____ Date _____

If student is not qualified, list reasons for disqualification: _____

(The following are considered disqualifying until medical and parental releases are obtained: acute infections, obvious growth retardation, diabetes, jaundice, severe visual or auditory impairment, pulmonary insufficiency, organic heart disease or hypertension, enlarged liver or spleen, hernia, musculoskeletal deformity associated with functional loss, history of convulsions or concussions, absence of one kidney, eye, or testicle.)