Sport requesting to participate in:_____

THE EPIPHANY SCHOOL OF GLOBAL STUDIES
ATHLETIC PARTICIPATION/MEDICAL HISTORY FORM

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

DATE:_____

STUDENT'S NAME_____
GRADE _____ **ADVISOR** _____

ADDRESS OF STUDENT_____

_____

HOME PHONE #_____ **DATE OF BIRTH** _____

PARENT'S NAME_____ **Parent's Work Phone:(Mother)#**_____
(Father)#_____

MEDICAL HISTORY *(to be completed by parents)*

STUDENT NAME_____ AGE_____ DATE_____

Is there any known history of:		**If "Yes" Explain:**
A. Birth deformities (one eye, one kidney, etc.).	Yes_____ No_____	_____
B. 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. **Allergy (drugs, food, clothing, etc.)**?	Yes_____ No_____	_____
G. Mental disorder or convulsions?	Yes_____ No_____	_____
H. **Do you take any medications regularly**?	Yes_____ No_____	_____
I. Does running or playing ever bother you? (Chest pains, cramps, or pain in your joints)	Yes_____ No_____	_____
J. Have you ever had a hernia rupture or any swelling in your groin area?	Yes_____ No_____	_____

If you need more room to explain any above questions answered "Yes" use the space provided below.

_____ _____
_____

- -

PARENTAL PERMISSION *(to be completed by parents)*

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

If your child/student should need emergency care immediately, please indicate which physician, and hospital you wish for us to deliver him/her to. Please complete the following Insurance and Emergency contact information:

Is your son/daughter presently covered by a Hospital Insurance policy? Yes____ No_____
(If the answer is "No", you will be required to secure insurance for your child.)

Health Insurance Company Name_____,
Insurance Policy #_____
Indicate Hospital Preference:_____

Physician's Name & Office Phone #_____
Signature of Parent or Legal Guardian:_____ Date_____
Parent's Emergency Phone #'s:_____
[Other person/people you would like us to contact _____ #_____
in the event you cannot be reached]: _____ #_____

PHYSICAL FORM *(to be completed by a physician)*

Student's Name_____ Date of Birth_____

Height_____ Weight_____ Blood Pressure_____

	NORMAL	ABNORMAL	DESCRIBE ABNORMALITIES:
1. Eyes	_____	_____	_____
2. ENT	_____	_____	_____
3. Heart	_____	_____	_____
4. Lungs	_____	_____	_____
5. Abdomen	_____	_____	_____
6. Genitalia	_____	_____	_____
7. Musculoskeletal	_____	_____	_____
8. Neurological	_____	_____	_____
9. Skin	_____	_____	_____

LABORATORY

URINALYSIS:_____

OTHER (Where Indicated):_____

_____

_____

I certify that I have examined this student and find him medically qualified to compete in the interscholastic sports listed.

Licensed to practice medicine in NC? Yes_____ No_____

Signature of Physician_____

Address _____

Physician Phone # _____

DATE OF PHYSICAL:_____

Physician; If the above named student is not qualified, please list reasons for disqualification:_____

_____

_____

THE EPIPHANY SCHOOL of GLOBAL STUDIES

Updated 6.25.13