

THE EPIPHANY SCHOOL

ATHLETIC PARTICIPATION/MEDICAL HISTORY FORM

This form is to be filled out completely and filed in the office of the Dean of Student Life 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)# _____

I hereby apply for permission to participate in the following interscholastic sport(s): _____

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: _____

