

School year _____



Athletic Participation Form

STUDENT INFORMATION: _____ / ____ / ____
(Name as it appears on birth certificate) (Grade) (Date of birth)

RESIDENCE: _____ / ____ / ____
(Street address) (City/zip) (Social security number)

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.

FATHER/MOTHER/GUARDIAN _____

IN THE EVENT OF AN EMERGENCY AND I AM UNABLE TO BE CONTACTED, PLEASE CONTACT THE

FOLLOWING: _____
(Name) (Relationship to named student) (Phone number)

EMERGENCY MEDICAL TREATMENT PERMISSION AND INFORMATION

I 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, 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.

Allergic and/or special medical problems (list any medication carried by student) _____

Family Physician _____ Phone _____

Hospital Preference _____ Date of last Tetanus Shot _____

STUDENT PARTICIPATION PERMISSION

I certify that all the 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.

(Legal signature of parent/guardian) (Telephone number) (Date) (Relationship)

**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