Faith Christian School
Athletic Participation Form

Student Information:

_____ Grade_____ Date of Birth_____
Name as it appears on birth certificate

_____ _____
Parent/Legal Guardian Parent/Legal Guardian

_____ _____
Street Address City

Health Insurance Information:

_____ __ ____ _____ _____
Company Name Group Number Policy 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. Payment of all charges incurred for medical treatment is guaranteed by me or the insurance company providing coverage for above-named student.

Allergies and/or special medical problems_____

List of Regular Medications_____

Date of last Tetanus shot_____ Preferred Hospital_____

Family Physician _____Phone Number_____

STUDENT PARTICIPATION PERMISSION

I give my permission for the above-named student to participate in organized interscholastic athletics, realizing that such activity involves the potential for injury which is inherent in all sports. I acknowledge that even with the best coaching, use of the most advanced protective equipment and strict observance of rules, injuries are still a possibility. On rare occasions these injuries can be so severe as to result in total disability, paralysis, quadriplegia or even death. I have read and understood the Faith Christian School Philosophy of Sports in the school handbook. I will make sure that my child is picked up on time from practices and games. I agree to be responsible for the safe return of all athletic equipment issued by the school to the above named student. I hereby give my consent for the above-named student to represent Faith Christian School in athletic activities, including team travel with the coach for local or out-of-town trips, except for those activities crossed out below.

Basketball	Volleyball	Soccer	Flag Football	Cheerleading	Golf
Cross Country	Track	Softball	Baseball	Tennis	

I have read this form and understand the rules contained herein, and that the information supplied is true and correct to the best of my knowledge. I accept the responsibility to inform the school of any future change of this information.

_____ _____
Student Signature School Attended Last Year

_____ _____ _____
Signature of Parent/Legal Guardian Cell Phone Number Date

_____ _____ _____
Signature of Parent/Legal Guardian Cell Phone Number Date

A PHYSICIAN MUST COMPLETE THIS SECTION

HEALTH EXAMINATION

_____ _____

Student Name Date of Birth

Age_____ Height_____ Weight_____ Blood Pressure_____

LIST SIGNIFICANT PAST ILLNESS OR INJURY

Eyes_____ R20/ L20/

Cardiovascular_____ Respiratory_____

Spleen_____ Liver_____

Musculo-Skeletal_____ Hernia_____

Neurological_____ Skin_____

Urinalysis_____

COMMENTS

I have examined the pupil and find him/her physically able to compete in supervised activities NOT CROSSED OUT BELOW:

Basketball	Volleyball	Soccer	Flag Football	Cheerleading	Golf
Cross Country	Track	Softball	Baseball	Tennis	

SIGNATURE OF EXAMINING PHYSICIAN_____ DATE_____

ADDRESS OF PHYSICIAN_____ PHONE_____