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)#__________________

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

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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.

____ ___________________________________

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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:_____

_____

_____

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