

Athletic Participation Requirements

Full Name of Student-Athlete: _____	Student must reside with parent(s) or guardian(s) listed below:
Social Security Number: _____	Name: _____
Date of birth: _____	Street Address: _____
Grade: _____	City: _____
Phone: Home: _____	Zip Code: _____
	Work: _____

Request for Permission: We the undersigned student and the student's parent/guardian, apply for permission to participate in interscholastic athletics in the following sports.		
<input type="checkbox"/> Basketball	<input type="checkbox"/> Golf	<input type="checkbox"/> Tennis
<input type="checkbox"/> Baseball	<input type="checkbox"/> Soccer	<input type="checkbox"/> Track
<input type="checkbox"/> Cross Country	<input type="checkbox"/> Softball	<input type="checkbox"/> Volleyball
<input type="checkbox"/> Football	<input type="checkbox"/> Swimming	<input type="checkbox"/> Wrestling

<p>Risk of Injury – We acknowledge and understand that there is a risk of injury involved in athletic participation. We understand that the student – athlete will be under the supervision and the instructions of the coach in order to reduce the risk of injury to the student and other athletes. However, we acknowledge and understand that neither the coach nor CMS can eliminate the risk of injury in sports. Injuries may and do occur. Sports injuries can be severe and in some cases may result in permanent disability or even death. We freely, knowingly, and willfully accept and assume the risk of injury that might occur from participation in athletics.</p>

<p>Release – In consideration of the CMS allowing the student-athlete to participate in athletics, we agree to release and hold CMS, its athletic coaches, and other employees free, harmless and indemnified from and against any and all claims, suits or causes of action arising from or out of an injury that the student-athlete may suffer from participation in athletics other than an injury resulting from gross or willful negligence.</p>

<p>Insurance – School Board Policy 5143 requires that all students who participate in athletics be adequately covered by medical or accident insurance. We certify that we have purchased and will maintain in full force and effect during student-athlete's participation in athletics the following insurance policy:</p>

Check One: School Accident Insurance Other Insurance Company

Name of other insurance company:

Street Address:

Policy No:

City, State, Zip

Group No:

Certification and Medical Authorization: We certify that all of the information provided by us on this form is correct. We agree to abide by the rules of the NCHSAA and CMS. We give our consent for the student to receive a medical screening examination prior to participation in athletics. If the student-athlete is injured while participating in athletics and the CMS employee is unable to contact the parent, we grant the CMS employee permission and the authority to obtain necessary medical care and/or treatment for the student's injury including first aid, medical or surgical treatment recommended by a physician and we accept the financial responsibility for such medical care or treatment.

Parent/Guardian Signature: _____

Date: _____

Medical History	Family Physician
To be completed by parents and student together. A "Yes" answer to any of the following questions will not automatically disqualify a student from participation in athletics.	

1. Has anyone in the athlete's family died suddenly before age 50? 2. Has the athlete ever stopped exercising because of dizziness or passed out during exercise? 3. Has the athlete ever been told that he/she has a heart murmur, heart problem or high blood pressure? 4. Has the athlete experienced chest pains with exercise or felt any extra strong or irregular heart beats? 5. Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercise? 6. Has the athlete ever had a broken bone, had to wear a cast, or had an injury to any joint? 7. Does the athlete have a history of a concussion (getting knocked out)? 8. Has the athlete ever suffered a heat related illness (heat stroke)? 9. Does the athlete have a chronic medical problem or see a doctor regularly for a particular problem? 10. Does the athlete have only one of a set of paired organs (If yes circle eye, ear, kidney, testicle, ovary)? 11. Does the athlete wear eyeglasses or contact lenses? 12. Is the athlete taking any medications? (If yes, what?) 13. Is the athlete allergic to any medications or insects? (If yes, what?) 14. Has the athlete had any operations/surgery? (If yes, describe.) 15. Has the athlete had a tetanus booster in the last ten years? (Date) 16. Does the athlete have anything he/she wants to talk to a doctor about?	1. Yes No 2. Yes No 3. Yes No 4. Yes No 5. Yes No 6. Yes No 7. Yes No 8. Yes No 9. Yes No 10. Yes No 11. Yes No 12. Yes No 13. Yes No 14. Yes No 15. Yes No 16. Yes No
Please explain any "Yes" answers. Student's Social Security Number _____	

Height:	Weight:	Blood Pressure:	Pulse:
Vision Rt :20/	Vision Lt: 20/	Vision Both: 20/	Optional – Body Fat (%)
Organ/System	Normal	Abnormal Explain)	
Eyes/Pupils			
ENT			
Heart			
Lungs			
Abdomen			
Genitalia			
Musculoskeletal			
Neurological			
Skin			
Laboratory (If indicated)			

DOCTOR'S CERTIFICATION: I, the undersigned physician, certify that I have examined this student and find him/her medically () Qualified () Qualified with conditions, or () unqualified to participate in athletics.	
Physicians signature	Street Address:
Date:	Telephone : City: State: Zip:

The following are considered disqualifying conditions until medical or parental releases are obtained: acute infections, obvious growth retardation, diabetes, jaundice, severe visual or auditory impairment, pulmonary insufficiency, organic heart disease or hypertension, enlarged liver or spleen, hernia, musculoskeletal deformity associated with functional loss, history of convulsions or concussions absence of one kidney, eye or testicle.