

**Charlotte-Mecklenburg Schools
Middle School Athletic Participation Form**

CHARLOTTE-MECKLENBURG SCHOOLS			PARENT PERMISSION INTERSCHOLASTIC ATHLETICS		
Name of Parent/Guardian: (Please Print)			Student-athlete: (Please Print)		Student ID:
Street Address:			School:		Grade:
City:	State:	Zip:	Date of Birth:		Phone: Home - 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"/> Cheerleading	<input type="checkbox"/> _____
<input type="checkbox"/> Baseball	<input type="checkbox"/> Soccer	<input type="checkbox"/> Track	<input type="checkbox"/> _____
<input type="checkbox"/> Football	<input type="checkbox"/> Softball	<input type="checkbox"/> Volleyball	<input type="checkbox"/> _____

General Requirements- We have read and discussed the general requirements for middle school athletic eligibility. We understand that additional questions or specific circumstances should be directed to our student's coach, athletic director or principal.

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 direction of a CMS athletic coach. We agree to follow the rules of the sport 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.

Release- In consideration of 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 any injury that the student-athlete may suffer from participation in athletics other than an injury resulting from gross or willful negligence.

Insurance- School Board Policy JLA 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 the student-athlete's participation the following insurance policy:

Check One: <input type="checkbox"/> School Accident Insurance <input type="checkbox"/> Name of Other Insurance Company:			Policy No:
Street Address:			Group No:
City:	State:	Zip :	Policy Term From: To:

CERTIFICATION AND MEDICAL AUTHORIZATION. We certify that all of the information provided by us on this form is correct. We agree to abide by state and local rules. 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 CMS is unable to contact the parent, we grant CMS permission and authority to obtain necessary medical care and/or treatment for the student's injury. Treatment may include, but is not limited to first aid, CPR, medical or surgical treatment recommended by a physician. We accept the financial responsibility for such medical care or treatment.

We, the undersigned student and parent, have read this document and understand all of the expectations for athletic participation at my middle school.

Student:	Date:
Parent/Guardian:	Date:

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MEDICAL HISTORY	Family Physician:
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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, but must be explained below.

Circle Answer

<ol style="list-style-type: none"> 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 heartbeats? 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 any 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? 	<ol style="list-style-type: none"> 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
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Please explain any "YES" answer:

DOCTOR'S EXAMINATION

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 (If indicated)		
Musculoskeletal		
Neurological		
Skin		

LABOBATORY (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.

The conditions for qualification or the reason(s) for disqualification are stated below:

Physician's 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, testicle or ovary.

