ATHLETIC PARTICIPATION FORM

INTERSCHOLASTIC SPORTS AND CHEERLEADING

☐ I (we), _____, hereby certify that my (our) child,

_____, is covered by the following insurance:

Name of insurance company: _____

Policy number: _____

Effective dates: _____

Name of insured: _____

☐ I do not have family medical insurance. (A student may not participate in the athletic program if he or she does not have medical insurance.)

Furthermore, I (we) accept complete responsibility for the cost of any medical treatment made necessary by my (our) child's participation in the school's athletic program. I (we) agree to keep the above insurance in effect during the entire school year while my (our) child is participating in school athletics.

I (we) further agree to hold the school harmless for any injury or illness arising out of my (our) child's participation in the school's athletic program.

_____ _____

PARENT OR GUARDIAN'S SIGNATURE DATE

_____ _____

PARENT OR GUARDIAN'S SIGNATURE DATE

STUDENT AGREEMENT

I agree to hold the school (faculty, staff, employees and any volunteers) harmless in the event of any injury or illness resulting from my participation in the school's athletic program.

_____ _____

STUDENT'S SIGNATURE DATE

Please note: A student's official eligibility to participate in the athletic program begins when this form is completed and returned. A student will not qualify for participation in any athletic events or practices until this form is on file in the school office.

THIS SECTION TO BE COMPLETED BY PARENT OR GUARDIAN

Student's name ______________________________ Date of birth ______________

LAST FIRST MIDDLE

Address ______________________________ Phone ______________

Student's physician ______________________________ Phone ______________

Medical conditions or restrictions ______________________________

Significant past illnesses or injuries ______________________________

Allergies (medication, insects, food, other) ______________________________

Medication taken regularly (name, dosage, purpose) ______________________________

My child carries an inhaler ________ EpiPen ________

Wears: □ Glasses □ Contact lenses

Date of most recent tetanus shot ______________________________

In the event of an emergency, please contact:

Name ______________ Relationship ______________ Phone (H) ______________

Phone (C) ______________

Name ______________ Relationship ______________ Phone (H) ______________

Phone (C) ______________

I give my permission for my child to ride the bus from and to Bob Jones Academy. I also give my permission for the sponsors of the activity to act in my behalf should my child become ill or injured and require emergency treatment.

Parent signature ______________________________ Date ______________

THIS SECTION TO BE COMPLETED BY PHYSICIAN

Student's name ______________________________ Grade ______ Age ______

Preexisting medical conditions ______________________________

Eyes ______________ Right 20/ ______________ Left 20/ ______________

Respiratory ______________ Cardiovascular ______________

Abdomen ______________ Musculoskeletal ______________

Other ______________________________

Comments ______________________________

I certify that I have, on this date, examined this student and found him or her physically able to compete in the following supervised activities: □ Basketball □ Cheerleading □ Soccer □ Volleyball

Date of examination ______________ Physician's signature ______________________________

Physician's address ______________________________