



MATTHEWS
CHRISTIAN ACADEMY

Physician and Parent Permission for Athlete Participation

DIRECTIONS: To be completed by parents and students 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.

Medical History			Family Physician:
Yes	No	Do Not Know	Question
			1. Has anyone in the athlete's family died suddenly before the age 50?
			2. Has the athlete ever had to stop exercising because of dizziness or passed out during exercise?
			3. Has the athlete ever been told he has a heart murmur, heart problem, or high blood pressure?
			4. Has the athlete experienced chest pains during exercise or felt any strong or irregular heartbeat?
			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 illness or see a doctor regularly for any particular problem?
			10. Does the athlete have only one of any paired organs? If yes, please circle: eye, ear, kidney, testicle, ovary.
			11. Does the athlete wear contacts or eyeglasses?
			12. Does the athlete take any medication? If yes, what?
			13. Is the athlete allergic to any medications or bee stings?
			14. Has the athlete had any operations or surgery? If yes, describe:
			15. Has the athlete had a tetanus booster in the last ten years? Yes No Date:
			16. Does the athlete have anything he wants to talk to the doctor about?

Please give details about any “yes” answers: _____

WARNING: Although participation in supervised interscholastic athletics maybe one of the least hazardous activities in which a student may engage in or out of school, **BY ITS NATURE, INTERSCHOLASTIC ATHLETICS INCLUDES A RISK OF INJURY WHICH MAY RANGE IN SEVERITY FROM MINOR TO LONG TERM CATASTROPHIC.** Although serious injuries are not common in supervised school athletic programs, it is impossible to eliminate this risk. Participants have the responsibility to help reduce the chance of injury. Players must obey all safety rules, report all the physical problems to their coaches, follow a proper conditioning program, and inspect their own equipment daily. By signing this form students, parents, and guardians acknowledge reading and understanding this warning. **THOSE WHO DO NOT WISH TO ACCEPT THE RISK DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS PERMISSION FORM.**

I have answered the above questions, as well as read the warning of inherent risk, and give permission for my child to participate in sports.

Parent's/Guardian's Signature _____ Date _____

Phone _____

Student's Signature _____ Date _____

Doctor's Examination

Height	Weight	Blood Pressure	Pulse
Vision: Right 20/	Vision: Left/20	Vision: Both 20/	Optional Body Fat %

ORGAN/SYSTEM	Normal	Abnormal (Please Explain)
Eyes/Pupils		
ENT		
Heart		
Lungs		
Abdomen		
Genitalia (If indicated)		
Musculoskeletal		
Neurological		
Skin		

Certification:

- () A. Unlimited participation
- () B. Limited to _____
- () C. Deferred until _____ (rehab, recheck, consultation, etc...)
- () D. Disqualified on the basis of _____

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

Re-Examine:

- () A. Yearly and after injury that limits participation for greater than one week.
- () B. Other _____

I certify that I have examined this student and such examination revealed () conditions () no conditions that would prevent him/her from participating on interscholastic sports.

Physician's signature _____ Date _____

Address _____

Phone _____

SRT

Revised 8/00: This form is adapted from the Child Health Committee of the Mecklenburg Co. (NC) Medical Society and other sources.