



Oconee Christian Academy Athletic Participation Form

This form is to be completely filled out and filed in the Oconee Christian Academy office before a student may participate in the Warrior Athletic program..

Student: _____ Grade: _____

Address _____

City: _____ State: _____ Zip: _____

Father's Name: _____ Phone: _____

Mother's Name: _____ Phone: _____

Family Physician: _____ Phone: _____

Address: _____

I hereby apply for permission to participate in the following sports: _____

I certify that the information contained in this application is correct, and I agree to abide by the Oconee Christian eligibility rules and regulations in the student handbook.

Student Signature Date

Parental Permission

As parent or legal guardian of _____, I hereby give my consent for his/her participation in the practice and play of the sports listed above. I also grant my permission for any treatment deemed necessary for conditions arising in the participation of 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 with the need for a medical screening examination, and certify that the medical history is accurate to the best of my knowledge. If my child's sports physical is being performed at Oconee Christian Academy, I understand that the examination is cursory and meant to screen out physical conditions which might limit my child's ability to participate in physical activity safely, and that this physical is in no way assurance that every and all medical conditions could be detected by this exam.

Parent Signature Date

Medical History

(to be completed by parents)

Student: _____ Birthdate: _____

Is there a known history of:	Yes	No
A. Birth defects? (heart defect, one kidney, etc)	<input type="checkbox"/>	<input type="checkbox"/>
B. Chronic medical conditions? (asthma, diabetes, hypertension etc)	<input type="checkbox"/>	<input type="checkbox"/>
C. Medical conditions currently under treatment?	<input type="checkbox"/>	<input type="checkbox"/>
D. Fractures of other disabling injuries?	<input type="checkbox"/>	<input type="checkbox"/>
E. Any permanent deformity or disability?	<input type="checkbox"/>	<input type="checkbox"/>
F. Allergies? (drugs, food, clothing, etc)	<input type="checkbox"/>	<input type="checkbox"/>
G. Significant chest pain during or after physical activity?	<input type="checkbox"/>	<input type="checkbox"/>
H. Passing out during or after physical activity?	<input type="checkbox"/>	<input type="checkbox"/>

Explain any above questions answered YES: _____

Surgical History

(List year of surgery and procedures performed)

Year	Procedure
_____	_____
_____	_____
_____	_____

Current Medications and Dosages

Notes

Examination

Intended Sports: _____

Student Name: _____ Date of Birth _____

Height _____ Weight _____ Blood Pressure _____

Urinalysis: Protein = POS NEG Glucose = POS NEG

Visual Acuity: Right Eye ____/____ Left Eye ____/____ Both Eyes ____/____

Normal		Abnormal	Describe Abnormality
	Eyes		
	ENT		
	Heart		
	Lungs		
	Abdomen		
	Genitalia (Males)		
	Musculoskeletal		
	Neurological		
	Skin		

Other: (where indicated): _____

I certify that I have examined this student and find him/her medically (qualified) (Not qualified) to compete in the sports above

Medical License No. _____ State: _____ Expiration Date _____

Doctor's Signature Date: _____

Address

If student is not qualified, list reasons for disqualification: _____

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 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 or one testicle.