



# GRACE

Christian School

## Athletic Department Authorization and Release Form

Participant's Full Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Parent/Legal Guardian \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Additional Emergency Contact \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Date of Last Tetanus Shot/Medications Now Being Taken \_\_\_\_\_

Participant is Allergic to: (Please list ALL) \_\_\_\_\_

List Any Unusual Health Information: \_\_\_\_\_

### Insurance Information

Name of Insurance Company: \_\_\_\_\_

ID Number: \_\_\_\_\_

We, \_\_\_\_\_ of the county of \_\_\_\_\_, N.C., the parents/legal guardians of \_\_\_\_\_ (Parents/legal guardians full names), a minor child, who resides with us, do hereby declare our intent to allow that child to practice, participate and travel with the athletic teams of GRACE Christian School in all related activities for the 2011-2012 season.

Recognizing the possibility of physical injury associated with sports participation and in consideration for GRACE Christian School accepting our child for its sports program and activities, we hereby release, discharge and/or otherwise agree to hold harmless and indemnify GRACE Christian School, its Board of Directors, its employees, volunteers, coaches, associated personnel, assistant coaches, and their agents, against any claim by us or on behalf of the minor child named herein as a result of said child's participation in the sports program and/or being transported to or from activities related thereto, which transportation we hereby authorize.

In addition, I/we request and authorize GRACE Christian School, its coaches, teachers, instructional assistants, staff, adult volunteers, and agents thereof, (1) to obtain medical or dental care for the aforementioned minor child, when, (a) in the judgment of said coaches, teachers, assistants, staff, volunteers or agents, such treatment is necessary for the minor child and (b) attempt(s) to reach me (us) have failed or in the judgment of said coaches, teachers, assistants, staff, volunteers or agents, the need for treatment is so immediate that there is not time to make such attempt(s), and (2) to authorize any x-ray examinations, anesthetic, diagnosis, medical, dental or surgical treatment, or hospital or clinic service that may be required by said minor in the estimation of a physician, whether such diagnosis or treatment is rendered at the office of said physician or at a hospital. It is understood that this authorization is given in advance of any specific diagnosis or required treatment and is given to encourage said hospital and said physician to exercise their best judgment as to the requirements of such diagnosis and treatment in those instances when a parent or guardian of the minor is unavailable to provide consent to treatment.

We further, jointly and severally, as parents and/or legal guardians of the minor child, hereby release, discharge, and agree to hold harmless and indemnify GRACE Christian School, its Board of Directors, its employees, volunteers, coaches, associated personnel, assistant coaches, and their agents from any and all liability, actions, causes of action, costs, expenses, compensation, damages, claims or demands arising from (1) the minor child participating in the sports program, specifically to include any and all claims for personal injuries sustained while present or participating in said sports program or while traveling to or from events or trips sponsored by or in conjunction with said sports program, (2) decisions made in selecting medical or dental providers or in authorizing medical or dental treatment, and (3) injuries or property damage resulting from treatment or transportation to and from any facility for the purpose of obtaining such treatment.

We, \_\_\_\_\_, being the parents/legal guardians of \_\_\_\_\_, a minor child wishing to participate in the GRACE Christian School sports program, have read and fully understand and agree to this WAIVER OF LIABILITY.

Both Parents/Guardians must sign this form.

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date



# GRACE

Christian School

Name \_\_\_\_\_ DoB \_\_\_\_\_ Date \_\_\_\_\_

Height \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Vision R \_\_\_\_/\_\_\_\_ - Uncorrected R \_\_\_\_/\_\_\_\_ - Corrected

Weight \_\_\_\_\_ %Body Fat \_\_\_\_\_ L \_\_\_\_/\_\_\_\_ - Uncorrected L \_\_\_\_/\_\_\_\_ - Corrected

|                                     | Normal | Abnormalities | Please Check if Child Experiences the following |
|-------------------------------------|--------|---------------|---|
| Eyes                                |        |               | <input type="checkbox"/> Asthma                 |
| Ears, Nose, Throat                  |        |               | <input type="checkbox"/> Bleeding Problems      |
| Mouth and Teeth                     |        |               | <input type="checkbox"/> Bowel Problems         |
| Neck                                |        |               | <input type="checkbox"/> Cancer/Leukemia        |
| Cardiovascular                      |        |               | <input type="checkbox"/> Attention/Learning     |
| Chest and Lungs                     |        |               | <input type="checkbox"/> Convulsions/Seizures   |
| Abdomen                             |        |               | <input type="checkbox"/> Cystic Fibrosis        |
| Skin                                |        |               | <input type="checkbox"/> Dental Problems        |
| Genitalia- Hernia (Male)            |        |               | <input type="checkbox"/> Diabetes               |
| Musculoskeletal ROM, Strength, Etc. |        |               | <input type="checkbox"/> Emotional/Behavioral   |
| Neck                                |        |               | <input type="checkbox"/> Ear Infections         |
| Spine                               |        |               | <input type="checkbox"/> Heart Problems         |
| Shoulders                           |        |               | <input type="checkbox"/> Meningitis             |
| Arms/Hands                          |        |               | <input type="checkbox"/> Sickle Cell Anemia     |
| Hips                                |        |               | <input type="checkbox"/> Vision Problems        |
| Thighs                              |        |               | <input type="checkbox"/> Skin Problems          |
| Knees                               |        |               | <input type="checkbox"/> Speech Problems        |
| Ankles                              |        |               | <input type="checkbox"/> Stomach Aches          |
| Feet                                |        |               | <input type="checkbox"/> Urinary/Bladder        |
| Neuromuscular                       |        |               | <input type="checkbox"/> Other _____            |

Physical limitations/Athletic restrictions: \_\_\_\_\_

Physician's Name \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Telephone Number \_\_\_\_\_

I certify that I have examined this student and found him/her medically qualified to participate in sports.

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_



**GRACE**  
Christian School

*Athletic Department*  
*Health History*

Athlete's Name \_\_\_\_\_ DoB \_\_\_\_\_ Date \_\_\_\_\_

**Athletes and Parents/Guardians- This health record is a critical element in the determination of an athlete's risk of injury in sports. Please take the time to read and answer all questions before seeing your physician for the athlete's physical examination.**

| Health History Questions  | Yes | No | Unsure |
|---|-----|----|--------|
| Has anyone in the athlete's family (grandparents, parents, siblings) died suddenly before age 50? |     |    |        |
| Has athlete ever stopped exercise because of dizziness or passed out during exercise?             |     |    |        |
| Does athlete have asthma (wheezing), hay fever, or coughing spells after exercise?                |     |    |        |
| Has athlete ever broken a bone, had to wear a cast, or had an injury to any joint?                |     |    |        |
| Does athlete have a history of concussion (getting knocked out, unconscious)?                     |     |    |        |
| Has athlete ever suffered heat related illness (heat stroke)?                                     |     |    |        |
| Does athlete have a chronic illness or see a doctor regularly for any particular problem?         |     |    |        |
| Does athlete take any medications?  |     |    |        |
| Is athlete allergic to any medications, foods, bee stings, etc.?                                  |     |    |        |
| Does athlete have only one of any paired organs (eyes, ears, kidneys, ovaries, testicles, etc.)   |     |    |        |
| Has athlete had an injury/illness in the last year that caused five/more consecutive absences?    |     |    |        |
| Has athlete had surgery or been hospitalized in the past year?                                    |     |    |        |
| Does athlete have a medical diagnosis that has not been resolved in the past year?                |     |    |        |
| Will any problem or condition affect athletic/school performance?                                 |     |    |        |

If yes, please explain in detail \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone Number \_\_\_\_\_ (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Work)

I have reviewed and answered the questions above and given permission for my child to participate in sports.

Parent/Guardian Signature \_\_\_\_\_

\_\_\_\_\_ Date