



Wake County High School Athletic Participation Form

Name: _____ Home Phone: _____ Circle Grade 9 10 11 12

Student ID # _____ School Attended Last Year _____

Gender: M F Date of Birth: _____ Race: _____ Age: _____

Father's Name: _____ Daytime Phone, Pager, Cell Phone: _____

Mother's Name: _____ Daytime Phone, Pager, Cell Phone: _____

*Legal Custodian: _____ Daytime Phone, Pager, Cell Phone: _____

***Please note the residency requirements and definition of legal custodian on page 4 of this document.**

Street Address: _____ County: _____

City: _____ State: _____ Zip Code: _____

Alternate Emergency Contact Person: _____ Daytime Phone: _____

Attach necessary documentation for Medical Alerts such as allergic reactions, contacts, etc.

Convictions: Check the box that applies to, _____ (student name):

Is not convicted of a felony in this or any other state **OR adjudicated** as a delinquent for an offense that would be a felony if committed by an adult in this or any other state

Is convicted of a felony in this or any other state

Is adjudicated as a delinquent for an offense that would be a felony if committed by an adult in this or any other state

The following must be completed if the student is convicted of a felony or is adjudicated as a delinquent:

Convicted or adjudicated of: _____

City and State: _____ Date Convicted/Adjudicated: _____

Description of Offense: _____

Court Counselor: _____ Telephone Number: _____

Request for Permission: We, the undersigned student and the student's parent/legal custodian, apply for permission to participate in interscholastic athletics in the following sports: (Please check all sports that apply)

- () Basketball () Football () Soccer () Track () Lacrosse
- () Baseball () Golf () Softball () Volleyball () _____
- () Cheerleading () Gymnastics () Swimming () Wrestling () _____
- () Cross Country () Indoor Track () Tennis *Weight lifting may be required component of conditioning for any sport.

Insurance: The Wake County Public School System (WCPSS) furnishes an Interscholastic Athletic Insurance Policy that provides limited benefits for all students in the system who participate in high school sponsored and supervised interscholastic athletic activities. The policy provides excess coverage for students with other insurance coverage, but it pays only when other benefits have been exhausted. In cases in which a student has no other coverage with either a commercial insurance agency, Medicare, or Medicaid, the WCPSS athletic insurance policy is the primary policy.

If your son or daughter should be injured while participating in a high school sponsored or supervised interscholastic athletic event, the following procedures must be followed to process a claim under the insurance provided by WCPSS:

- Pick up a claim form at your school.
- See a physician within 30 days of the injury.
- Complete and submit the Accident Claim form. The claim form must be filed with the insurance company within 60 days of the injury and should include the Explanation of Benefits form from your primary insurance carrier. Please list below the name of your primary insurance carrier and policy number.

Name of Insurance Company

Policy Number

NAME:

Class of

NAME: _____

Date of Birth: _____

Athletes and parents: 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 circle the correct responses before seeing a physician for the athlete's physical examination.

1.	Has anyone in the athlete's family (grandparents, mother, father, brother, sister, aunt, uncle) died suddenly before age 50?	YES	NO	DON'T KNOW
2.	Has the athlete ever stopped exercising because of dizziness or passed out during exercise?	YES	NO	DON'T KNOW
3.	Does the athlete have asthma (wheezing), hay fever or coughing spells after exercise?	YES	NO	DON'T KNOW
4.	Has the athlete ever had a broken bone, had to wear a cast, or had an injury to any joint?	YES	NO	DON'T KNOW
5.	Does the athlete have a history of a concussion (being knocked out)?	YES	NO	DON'T KNOW
6.	Has the athlete ever suffered a heat-related illness (such as heat stroke or heat exhaustion)?	YES	NO	DON'T KNOW
7.	Does the athlete have a chronic illness or see a doctor regularly for any particular problem?	YES	NO	DON'T KNOW
8.	Does the athlete take any medication(s)?	YES	NO	DON'T KNOW
9.	Is the athlete allergic to any medications or bee stings?	YES	NO	DON'T KNOW
10.	Does the athlete have only one of any paired organ? (eyes, kidneys, testicles, ovaries, etc.)	YES	NO	DON'T KNOW
11.	Has the athlete had an injury in the last year that caused the athlete to miss three or more consecutive days of practice or competition?	YES	NO	DON'T KNOW
12.	Has the athlete had surgery or been hospitalized in the past year?	YES	NO	DON'T KNOW
13.	Has the athlete missed more than five consecutive days of participation in usual activities because of an illness, or has the athlete had a medical illness diagnosed that has not been resolved in the past year?	YES	NO	DON'T KNOW
14.	Are you, the athlete, worried about any problem or condition at this time?	YES	NO	DON'T KNOW
15.	Does the athlete have diabetes?	YES	NO	DON'T KNOW
16.	Is there a family history of diabetes?	YES	NO	DON'T KNOW

*Please give details on any "YES" answer from the above health history.

PHYSICAL EXAM – TO BE COMPLETED BY PHYSICIAN

Height _____ Weight _____ Percent body fat (optional) _____ Pulse _____ Blood Pressure _____
 Vision: R _____ / _____ uncorrected R _____ / _____ corrected L _____ / _____ uncorrected L _____ / _____ corrected

	Normal	Abnormal Findings	Initials
1. Eyes			
2. Ears, Nose, Throat			
3. Mouth & Teeth			
4. Neck			
5. Cardiovascular			
6. Chest & Lungs			
7. Abdomen			
8. Skin			
9. Genitalia-Hernia (male)			
10. Musculoskeletal: ROM, strength, etc.			
• Neck			
• Spine (Scoliosis)			
• Shoulders			
• Arms/hands			
• Hips			
• Thighs			
• Knees			
• Ankles			
• Feet			
11. Neuromuscular			
12. Diabetes – check appropriate answers	YES	NO	
IF YES, INSULIN-DEPENDENT	YES	NO	NON-INSULIN DEPENDENT YES <input type="checkbox"/> NO <input type="checkbox"/>

Comments re: Abnormal Findings:

Please Print/Stamp	Triangle Pediatric Center, PA
Physician's Name	101 SW Cary Parkway
Street Address	Suite 270
City, State, Zip Code	Cary, NC 27511
Telephone	tel: 919-467-5543

I certify that I have examined this athlete and found him/her medically qualified to participate in sports. I also certify that I am a licensed medical physician, physician's assistant, or family nurse practitioner in the United States. (Doctor of Chiropractic Medicine is not satisfactory).

Physician's Signature: _____ Date: _____

PARTICIPATION RESTRICTIONS: