



Wake County Public School System

Middle School Athletic Participation Form

Name: _____ Home Phone #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Gender: M / F Date of Birth: _____ 19____ Age: _____ Grade: _____

Father's Name: _____ Place of Employment: _____

Daytime Phone #: _____ Pager #: _____ Cellular #: _____

Mother's Name: _____ Place of Employment: _____

Daytime Phone #: _____ Pager #: _____ Cellular #: _____

Alternate Emergency Contact Person: _____

Relationship: _____ Daytime Phone: _____

Insurance: The Wake County Public School System (WCPSS) does not carry accident or medical insurance to cover students' accidental injuries or illnesses. A student accident insurance policy is available on an individual basis and covers accidental injuries that occur during school-sponsored activities. Application and purchase information can be obtained from your child's school. In addition, parents' insurance may also provide coverage for injuries to their child(ren). WCPSS Board policy (6720) addresses the insurance requirements for participating in specified activities.

6720.1 Every student participant in a student activity, which requires accident insurance, shall:
A: Furnish proof of membership in the student accident insurance program, or
B: Furnish proof that compatible coverage is carried in another insurance policy.

6720.2 Student activities requiring student activity insurance coverage are: A) Interscholastic athletic programs, B) Intramural athletic programs, C) Marching Bands, D) School Patrols, E) Cheerleaders, F) Groups making overnight trips or excursions.

Your child has indicated an interest in participating in a student activity, which requires accident insurance coverage. Please check A or B below to indicate the method by which the required coverage will be provided. A policy number is **required** for choice A.

___ A. My child is adequately covered by accident and/or health and/or hospital insurance policy that is in effect during the present school year. This coverage is through:

Name of Insurance Company Policy Number

___ B. My child is enrolled in the WCPSS student accident insurance program. I understand that my child is covered upon receipt of the completed application and appropriate premium by WCPSS.

Verification of School Administration Date

Assumption of Risk: It is understood and acknowledged that there is a risk of injury involved in athletic participation. The student athlete will be under the supervision and direction of a WCPSS athletic coach. Following the rules of the game and the instructions of the coach can reduce the risk of injury to the student and to other athletes. However, it is understood that neither the coach nor WCPSS can eliminate the risk of injury in sports. Injuries may and do occur. Sports injuries can be severe and in some cases may result in permanent disability or even death. We freely, knowingly, and willfully accept and assume the risk of injury that might occur from participation in athletics.

Name

Grade

Track

Name _____

Date of Birth _____

Student Athlete Health History: This health record history 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

*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			
• Shoulders			
• Arms/hands			
• Hips			
• Thighs			
• Knees			
• Ankles			
• Feet			
11. Neuromuscular			

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 physical, physician's assistant, or family nurse practitioner in the United States. (Doctor of Chiropractic Medicine is not satisfactory).

Physician's Signature: _____ Date: _____

PARTICIPATION RESTRICTIONS: