Bob Jones Academy

ATHLETIC PARTICIPATION FORM

INTERSCHOLASTIC AND INTRAMURAL SPORTS

☐ I (we), _____, hereby certify that my (our) child,

_____, is covered by the following insurance:

Name of insurance company: _____

Policy number: _____

Effective dates: _____

Name of insured: _____

☐ I do not have family medical insurance. (A student may not participate in the athletic program if he or she does not have medical insurance.)

Furthermore, I (we) accept complete responsibility for the cost of any medical treatment made necessary by my (our) child's participation in the school's athletic program. I (we) agree to keep the above insurance in effect during the entire school year while my (our) child is participating in school athletics.

I (we) further agree to hold the school harmless for any injury or illness arising out of my (our) child's participation in the school's athletic program.

_____ _____

PARENT OR GUARDIAN'S SIGNATURE DATE

_____ _____

PARENT OR GUARDIAN'S SIGNATURE DATE

STUDENT AGREEMENT

I agree to hold the school (faculty, staff, employees and any volunteers) harmless in the event of any injury or illness resulting from my participation in the school's athletic program.

_____ _____

STUDENT'S SIGNATURE DATE

Please note: A student's official eligibility to participate in the athletic program begins when this form is completed and returned. A student will not qualify for participation in any athletic events or practices until this form is on file in the school office.

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THIS SECTION TO BE COMPLETED BY PARENT OR GUARDIAN

Student's name _____ Date of birth _____
LAST FIRST MIDDLE

Address _____ Phone _____

Student's physician _____ Phone _____

Medical conditions or restrictions _____

Significant past illnesses or injuries _____

Allergies (medication, insects, food, other) _____

Medication taken regularly (name, dosage, purpose) _____

Wears: ☐ Glasses ☐ Contact lenses

Date of most recent tetanus shot _____

In the event of an emergency, please contact:

Name _____ Relation _____ Phone _____

Name _____ Relation _____ Phone _____

I give my permission for my child to ride the bus from and to Bob Jones Academy. I also give my permission for the sponsors of the activity to act in my behalf should my child become ill or injured and require emergency treatment.

Father's signature _____ Phone _____

Mother's signature _____ Date _____

THIS SECTION TO BE COMPLETED BY PHYSICIAN

Student's name _____ Grade _____ Age _____

Preexisting medical conditions _____

Eyes _____ Right 20/ _____ Left 20/ _____

Respiratory _____ Cardiovascular _____

Abdomen _____ Musculoskeletal _____

Other _____

Comments _____

I certify that I have, on this date, examined this student and found him or her physically able to compete in the following supervised activities: ☐ Basketball ☐ Cheerleading ☐ Soccer ☐ Volleyball

Date of examination _____ Physician's signature _____

Physician's address _____