Student Health/Participation Form **2023-2024 school year**

STUDENT INFORMATION: _____ _____ ____/____/____
(Name as it appears on birth certificate) (Grade) (Date of birth)

RESIDENCE: _____
(Street address) (City/zip)

INSURANCE: As the parent/guardian of the above named student I understand that the school's insurance that is furnished as part of the registration fee, will serve as a secondary insurance to any policy I may have. In the event that I do not have insurance, the school's policy will serve as the primary policy.

*FATHER/MOTHER/GUARDIAN_____

IN THE EVENT OF AN EMERGENCY AND I AM UNABLE TO BE CONTACTED, PLEASE CONTACT:

_____ _____ _____
(Name) (Relationship to student) (Cell phone number)

EMERGENCY MEDICAL TREATMENT PERMISSION AND INFORMATION

I hereby authorize the school to obtain, through a physician of its own choice, any emergency care that may become reasonably necessary for the student in the course of activities or travel. I, or the insurance company providing coverage for above named student, guarantee payment of all charges incurred for medical treatment. I also give consent for the administration to administer pain relievers if necessary.

Allergic and/or special medical problems (list any medication carried by student) _____

_____

Physician _____ _____
(PLEASE PRINT) (Office Number)

Hospital Preference _____ Date of last Tetanus Shot _____

STUDENT PARTICIPATION PERMISSION

I certify that all the information in this application is correct and I agree to abide by the eligibility rules and regulations governing as set forth by the Association in which Northside Christian Academy is a member.

_____ _____ _____
(*Legal signature of parent or guardian listed above) (Cell phone number) (Date)

THIS SECTION TO BE COMPLETED BY PHYSICIAN

AGE: _____ HEIGHT: _____ WEIGHT: _____ B/P: _____ VISUAL: _____

CARDIOVASCULAR: _____ ABDOMEN: _____ MUSCULO-SKELETAL _____

NEUROLOGICAL: _____ SKIN: _____ LIVER: _____ HERNIA _____

URINALYSIS: _____ SCOLIOSIS: _____ OTHER: _____

SIGNATURE OF EXAMINING PHYSICIAN _____ Provider ID _____

LICENSED TO PRACTICE MEDICINE IN NORTH CAROLINA? YES___ NO___

DATE: _____
Physical expires one year from date)