FRANKLIN CLASSICAL SCHOOL ATHLETIC PERMISSION AND POLICY FORM

PART I - Parent Permission (To be completed by a parent of all perspective athletes)

Student's Name: _____ Grade _____ School Year: ____ Sex ___ Date of Birth _____

1) I hereby give consent for the above-named student to participate in interscholastic athletics at Franklin Classical School for the school year listed in the heading.

2) I understand and agree to release and hold harmless Franklin Classical School and any affiliated coaches, drivers, and faculty for any injuries my child may sustain traveling to, from, or participating in scheduled games and practices. I am aware that the sports my child participates in may well involve physical contact and/or collisions of a violent nature, either purposely or accidentally, that all sports are considered inherently dangerous, and that the potential for serious injury may be substantial.

3) I have obtained insurance coverage for my child. Payment of medical bills will be my responsibility should an injury occur.

4) I am also aware that physical examinations are the parents' responsibility to schedule in order to clear the student for athletic participation. Evidence of the physical examination, dated no earlier than May 1st, and as recorded on the bottom of the FCS Medical Release (or similar) form by a physician or physician's assistant, must be given to the athletic department of FCS before a student participates in tryouts, practice, or athletic events.

My signature below indicates that I have read this form and agree to its contents.

Parent or Guardian Signature: _____ Date _____

Parent or Guardian Name Printed: _____

PART II - Medical Exam (To be completed by a licensed physician or physicians' assistant)

*** {similar forms from a physician are acceptable substitutes for Part II of this form} ***

Height: _____ Weight: _____ Blood Pressure: _____

Vision: Left ____/____, Right ____/____, Bi-lateral ____/____

	Satisfactory	Unsat.	No Exam		Satisfactory	Unsat.	No Exam
Hearing				Musculoskeletal			
Respiratory				Skin			
Cardiovascular				Neurological			
Hernia, Genitalia				Lab Test (specify below)			
Liver/Spleen/Kidney				Other: _____			

If any of the above are "Unsatisfactory" please explain- _____
_____

Does patient have any allergies (medicine, bees, stinging insects)? Please explain- _____
_____ Is patient taking any current medication? Please list medication and potential athletic complications- _____
_____

I certify that I have examined the above listed student and find him/her COMPLETELY ABLE to participate in interscholastic sports, subject to the limitations listed below this line.

Limitations (if none please leave blank):

Physician or PA's Name (printed): _____

Physician or PA's Signature: _____

Date of Exam: _____ Phone Number: ( ) _____