



## Faith Christian School

### 2025-2026 Athletics Participation & Physical Exam Card

Note: Student CANNOT practice/participate without turning in this form

Return to FCS Athletic Director  
BEFORE first practice

#### SECTION 1: ATHLETE INFORMATION

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Incoming Grade \_\_\_\_\_ Address \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_  
Parent/Guardian Name & Phone Number \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Alternative Parent/Guardian Name & Phone Number \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Medical information that affects athlete in practice or games (i.e. allergies, medications)  
\_\_\_\_\_

#### SECTION 2: PERMISSIONS

I hereby give my permission for the above-named student to practice, compete, travel with, and represent Faith Christian School in WIAA approved interscholastic sports except those restricted on this card.

#### EMERGENCY MEDICAL CARE

Parents/guardians need to provide all health concerns/protocols/medications to the coach/athletic trainer. I grant permission for the above student, in case of accident or injury during athletic participation, to be given emergency attention/care by the athletic trainer, team physician, or any other physician present and to be conveyed to an emergency medical facility if needed. I understand that all costs associated with such treatment will be the responsibility of the parents/guardians, and that Faith Christian School will assume no liability for the costs.

Pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder (collectively known as "HIPPA"), I authorize health care providers of the student named above, including emergency medical personnel and other similarly trained professionals that may be attending an interscholastic event or practice, to disclose/exchange essential medical information regarding the injury and treatment of this student to appropriate school district personnel such as, but not limited to: principal, athletic director, athletic trainer, team physician(s), team coach(es), assistant athletic director and/or other professional health care providers, for purposes of treatment, emergency care and injury recordkeeping.

#### INFORMED CONSENT

I understand and accept that there are certain physical risks incumbent upon participation in athletics and transportation to and from athletic practices and games. Faith Christian School does not carry a student insurance policy, student-athletes are covered under family policies. Further, the student (or parent/guardian) releases and promises to indemnify, defend, and hold harmless the athletic sponsor for any injury arising directly or indirectly out of the described activity or transportation to and from the activity, whether such injury arises out of the negligence of the athletic sponsor, the student, or otherwise. I realize that Faith Christian School is not responsible for and does not provide insurance of any kind for its students. Knowing this, I hereby give the above-named student permission to participate in athletics for this school year.

#### FCS CODE OF CONDUCT

The above-named student will be participating in a sport at Faith Christian School. A copy of the Athletic Handbook is on the parent portal, available in the FCS Athletic Office, and at registration. By signing this form, we are attesting to the fact that we have read, understand, and will abide by all of the information contained in the handbook. We further certify that if we have not understood any information contained in this document, we have sought and received an explanation of the information prior to signing this statement. We realize the rules and regulations are in effect year-round, on and off the playing court/field.

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Student-Athlete

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Signature Date

**SECTION 3: COMPLETE ONLY ONE OF THE BOXES BELOW AS IT APPLIES TO YOUR ATHLETE.**

**ALTERNATE YEAR CARD- ONLY IF YOU FILED A SPORTS PHYSICAL LAST YEAR.** (Note: Freshmen complete Sports Physical Exam Card)

☐ Check this box ONLY if you filed a sports physical with FCS Athletics last school year; AND the student has not had a surgery, serious injury or illness that needs another medical evaluation prior to participating in athletics this school year.

**Date of Last Physical:** \_\_\_\_\_ **NOTE:** Physicals dated AFTER April 1 are good for the following TWO SCHOOL YEARS. Physicals dated BEFORE April 1 are good for the remainder of that school year and the following school year.

**IF YOU NEED A NEW SPORTS EXAM** (due to a surgery or serious medical condition), OR you are an incoming freshman, junior, transfer, OR haven't had a physical since April 1, 2024 you need a sports physical. Have the doctor complete the card below.

**SPORTS PHYSICAL EXAM CARD- PHYSICIAN COMPLETES** (Physician/PA/APNP Completes AND Signs)

☐ **CLEARED** without restrictions for all sports      Date of Exam \_\_\_\_\_

☐ **NOT CLEARED**      \_\_\_\_\_ Pending further exam      \_\_\_\_\_ For all sports      \_\_\_\_\_ For certain sports

Give reason/restriction if not cleared \_\_\_\_\_

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians.)

Signature of Licensed Physician (MD or DO)/PA/APNP \_\_\_\_\_

Clinic \_\_\_\_\_

Address \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Street Address      City      State      Zip

\*Physicians may authorize Nurse Practitioners to stamp this card with the physician's signature or name of clinic