NO MORE SIDELINES

Application for Participation - Medical Background Information

Section A - Applicant's Personal Information

_____ _____ _____ _____

First name and middle initial | Last Name | Social Security Number | Date of Birth (mm/dd/yyyy)

_____ _____ _____ _____

Street Address | City | State | Zip code

Home phone: (_____)_____Cell/alternative phone (_____)_____ Gender: Male / Female

PLEASE CHECK ALL DIAGNOSIS THAT APPLIES TO PARTICIPANT:

- ☐ Cerebral Palsy
- ☐ Autistic
- ☐ Asperger's Syndrome
- ☐ Down Syndrome
- ☐ ADD/ADHD
- ☐ Epilepsy/Seizure Disorder
- ☐ Wheelchair Bound
- ☐ Motor Impairment
- ☐ Cognitive Impairment
- ☐ Fetal Alcohol Syndrome
- ☐ Bi-polar
- ☐ Emotional/Behavioral issues
- ☐ Other_____
  _____
  _____

_____ _____ _____

Parent/Guardian First Name | Last Name | Full address (city/state/zip)

Parent/Guardian phone: Day (_____) _____ Evening (_____) _____ Cell (_____) _____

Email address: _____

_____ _____

Insurance Company | Policy number

_____ _____ (_____)_____

Emergency Contact | Street Address (city/state/zip) | Emergency phone number

Section B - Applicant Health Data

Please check all of the following health questions that apply and can be answered yes and provide the requested information (leave blank if answer is no or does not apply). Do you have or have you any of the following health conditions:

_____ Asthma or exercise induced wheezing

_____Concussions/serious head injury, Date _____

_____Bed wetter

_____Shunt

_____Immunizations are up to date

_____Chest pain/Fainting spell/Heat stroke/Exhaustion

_____Heart disease/Heart defect/High blood pressure

_____Blood-borne contagious infection carrier (for example, HIV, Hepatitis B)

_____Bone or joint disorder

_____Visual impairment or correction (for example, blind or wears glasses/contacts)

_____ Major surgery or serious illness

_____Diabetes, Indicate type I_____ or II _____

_____If Down syndrome, have x-rays been taken for atlantoaxial instability? Date of xray _____

_____If Down Syndrome, was AL present ? _____

_____Motor Impairment/requiring special equipment

_____Tendency to bleed

_____Deformities (for example, curvature of back, single kidney, one testicle, etc.

_____Special diet

_____Emotional/Psychiatric/Behavior troubles

_____Urination/bowel problem

_____Hearing impairment or correction

_____Dental concerns (for example, dentures, braces, chipped teeth, etc.)

_____Other or new problems that would interfere with or modify or limit sports participation (for example, wheelchair, other assistive devices)

_____Allergies, If so: _____Medicines _____Foods _____ Insect bites/stings _____ Other; If yes to any, list each known specific allergy:

_____

Section C - Medications

List Medications taken by the applicant. If more than three (3) medications, attach a separate sheet listing all medications.

Medication Name	Dosage	Time(s) Administered	Date Prescribed

Section D - Parent or Guardian Release

By completing and submitting this form, I hereby request permission for the above named applicant to participate in activities of No More Sidelines, a non-profit corporation. I represent and warrant that I am familiar with such activities and that the applicant is physically and mentally able to participate in NMS activities and I submit a subscribed medical certificate for that purpose.

I authorize NMS to take such measures and arrange for such medical and hospital treatment as may be deemed advisable for the health and well-being of the applicant in the event that she or he becomes ill or injured at any NMS activity and when no responsible adult, authorized to act on the applicant's behalf is immediately available to be consulted regarding the appropriate and necessary medical care for the applicant.

By signing below, I acknowledge that I have read, fully understand and agree to be bound by the provisions of this release.

_____ _____

Signature of Parent or Guardian Date

Section E - Medical Certification to be completed by physician or other medical professional (examiner):

Skin_____ Head_____ Eyes_____ Ears_____ Nose_____ Mouth/Throat_____

Neck_____Lungs_____Heart_____Abdomen_____Extremities_____Genital_____

Height_____ Weight_____ Blood pressure_____

List health concerns that No More Sidelines should be aware of for this participant (attach additional sheet if required):

I have examined the individual named in this application and reviewed the health data in Section B and certify that there is no medical evidence available to me which would preclude this athlete from participation in No More Sidelines activities.

_____

Signature of Examiner Date

_____

Print Examiner's Name Examiner's Title (MD, DO, CNP, PA)

_____(_____)_____

Examiner's Full Address Examiner's Office Telephone Number