

PARENT/GUARDIAN CONSENT FORM

Parent/Guardian consent, medical history, and physical evaluation are to be completed:

- 1. Annual
- 2. Before any practice (both in-season and out-of-season) or games/matches.
- 3. For any student 7th grade through high school participating in a sport.

Student's Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Age: _____ Grade: _____ Sex: _____

Home Street Address: _____

City: _____ State: _____ Zip Code: _____

Mom/Guardian: Home #: _____ Cell/Pager #: _____

Work Place: _____ Work #: _____

Father/Guardian: Home #: _____ Cell/Pager #: _____

Work Place: _____ Work #: _____

Name of Insurance Provider: _____ Policy Number: _____

Name of Insured: _____ Social Security Number: _____

Physician's Name: _____ Phone: _____

Dentist's Name: _____ Phone: _____

MEDICAL INFORMATION

Date of Student's Last Tetanus Booster Vaccination: _____

Drug Allergies or Other Medical Conditions: _____

In case of Emergency, where the above people can not be located, call:

_____ Home #: _____ Work #: _____ Cell/Pager #: _____

_____ Home #: _____ Work #: _____ Cell/Pager #: _____

Consent

I, _____, grant permission for my child _____ to participate in extracurricular athletic activities. These activities will take place under the guidance and direction of school employees and/or volunteers. As a parent and/or legal guardian, I remain legally responsible for personal actions taken by the above named minor ("student"). I agree on behalf of myself, my child named herein, our heirs, successors and assigns, to hold harmless and defend _____, its employees, officers, directors and agents, and the Diocese of Galveston-Houston, or representatives associated with the activity for reasonable attorney's fees and expenses arising in connection therewith.

I hereby warrant to the best of my knowledge, that my child is in good health, and I assume all responsibility for the health and medical care of my child. In the event of a medical emergency, I hereby give permission to school employees and/or volunteers supervising the athletic event to obtain medical services and to transport my child to the nearest hospital/emergency care center for emergency medical or surgical treatment.

Parent/Guardian Signature

Relationship

Date

PHYSICAL EXAMINATION FORM

Student's Name: _____ Height: _____ Weight: _____ Pulse: _____ Blood Pressure: _____

Vision R 20/ _____ L 20/ _____ Corrected: Yes _____ No _____ Pupils: Equal _____ Unequal _____

Hearing: Normal _____ Referred _____ Spinal Exam: Normal _____ Referred _____ %Body Fat (optional) _____

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS
Appearance			
Eyes/Ears/Nose/Throat			
Heart-Auscultation of the heart in the supine position			
Heart-Auscultation of the heart in the standing position			
Heart-Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			

MUSCULOSKELETAL

Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

Please check any activity that this student is not to participate in:

- | | | | |
|---|-------------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Baseball | <input type="checkbox"/> Football | <input type="checkbox"/> Tennis | <input type="checkbox"/> Wrestling |
| <input type="checkbox"/> Basketball | <input type="checkbox"/> Golf | <input type="checkbox"/> Soccer | <input type="checkbox"/> Swimming & Diving |
| <input type="checkbox"/> Cross Country | <input type="checkbox"/> Water Polo | <input type="checkbox"/> Lacrosse | <input type="checkbox"/> Track & Field |
| <input type="checkbox"/> Physical Education | | | |

CLEARANCE

- Cleared for Participation
- Not cleared for Participation Reason: _____

Recommendations and/or Restrictions: _____

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, or a Registered Nurse recognized as an Advanced Practiced Nurse by the Board of Nurse Examiners.

Name (print/type): _____ Date of Examination: _____

Address: _____ Phone Number: _____

Signature: _____ Title: _____

MEDICAL HISTORY FORM

Student Name: _____ Date of Birth: _____

Explain "Yes" answers at end of form. Circle questions for which you don't know the answers.

The student with the help of the parent or guardian is to answer the following questions:

- 1. Have you had a medical illness or injury since your last check up or sports physical? Yes ___ No ___
2. Have you been hospitalized overnight in the past year? Yes ___ No ___
Have you had surgery in the past year? Yes ___ No ___
3. Are you currently taking any prescriptions or non-prescription (over the counter) medication or pills or using an inhaler? Yes ___ No ___
4. Do you have any allergies (for example, to pollen, medicine, food or stinging insects)? Yes ___ No ___
5. Have you ever passed out during or after exercise? Yes ___ No ___
Have you ever been dizzy during or after exercise? Yes ___ No ___
Have you ever had chest pain during or after exercise? Yes ___ No ___
Do you get tired more quickly than your friends during exercise do? Yes ___ No ___
Have you ever had racing of your heart or skipped heartbeats? Yes ___ No ___
Have you ever been told you have a heart murmur? Yes ___ No ___
Has any family member or relative died of heart problems or of sudden unexpected death before age 50? Yes ___ No ___
Has any family member been diagnosed with enlarged heart, hypertrophic cardiomyopathy, long QT symptom, Marfan's syndrome, or abnormal heart rhythm? Yes ___ No ___
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? Yes ___ No ___
Has a physician ever denied or restricted your participation in sports for any heart problems? Yes ___ No ___
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters?) Yes ___ No ___
7. Have you ever had a head injury or concussion? Yes ___ No ___
Have you ever been knocked out, become unconscious, or lost your memory? Yes ___ No ___
If yes, how many times? ___ When was the last concussion? ___
How severe was each one? (Explain in the spaced provided.) ___
Have you ever had a seizure? Yes ___ No ___
Do you have frequent or severe headaches? Yes ___ No ___
Have you ever had numbness or tingling in your arms, hands, legs or feet? Yes ___ No ___
Have you ever had a stinger, burner, or pinched nerve? Yes ___ No ___
8. Have you ever become ill from exercising in the heat? Yes ___ No ___
9. Have you ever gotten unexpectedly short of breath with exercise? Yes ___ No ___
Do you cough, wheeze, or have trouble breathing during or after activity? Yes ___ No ___
Do you have asthma? Yes ___ No ___
Do you have seasonal allergies that require medical treatment? Yes ___ No ___
10. Have you had any problems with your eyes or vision? Yes ___ No ___
11. Are you missing any paired organs? Yes ___ No ___
12. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, and retainer on your teeth, hearing aid?) Yes ___ No ___

MEDICAL HISTORY FORM - PART 2

Student Name: _____ Date of Birth: _____

- 13. Have you ever had a sprain, strain, or swelling after injury? Yes ___ No ___
- Have you broken or fractured any bones or dislocated any joints? Yes ___ No ___
- Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? Yes ___ No ___
- If yes, check the appropriate one and explain below.

- | | | |
|------------------------------------|----------------------------------|------------------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> Elbow | <input type="checkbox"/> Hip |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Forearm | <input type="checkbox"/> Thigh |
| <input type="checkbox"/> Back | <input type="checkbox"/> Wrist | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Hand | <input type="checkbox"/> Shin/Calf |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> Finger | <input type="checkbox"/> Ankle |
| <input type="checkbox"/> Upper Arm | | <input type="checkbox"/> Foot |

- 14. Do you want to weigh more or less than you do now? Yes ___ No ___
- Do you lose weight regularly to meet weight requirements for your sport? Yes ___ No ___
- 15. Do you feel stressed out? Yes ___ No ___

16. Record the dates of your most recent immunizations (shots) or disease for:

Tetanus _____	Measles _____
Hepatitis B _____	Chicken Pox _____

- 17. Are you currently under a doctor's care? Yes ___ No ___

FOR FEMALES ONLY:

- 18. When was your first menstrual period? _____
- When was your most recent menstrual period? _____
- How much time do you usually have from the start of one period to the start of another? _____
- How many periods have you had in the last year? _____
- What was the longest time between periods in the last year? _____

Explain "Yes" answers here:

Please list all prescribed medication taken by your child:

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____