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:

__ Baseball
__ Basketball
__ Cross Country
__ Physical Education
__ Football
__ Golf
__ Water Polo
__ Tennis
__ Soccer
__ Lacrosse
__ Wrestling
__ Swimming & Diving
__ Track & Field

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.

__ Head	__ Elbow	__ Hip
__ Neck	__ Forearm	__ Thigh
__ Back	__ Wrist	__ Knee
__ Chest	__ Hand	__ Shin/Calf
__ Shoulder	__ Finger	__ Ankle
__ Upper Arm		__ 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: ______