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, when the above people cannot 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 Archdiocese of Galveston-Houston, or representatives associated with these activities, arising from or in connection with my child participating in these activities, or in connection with any illness, injury or cost of medical treatment in connection therewith, and I agree to compensate _____ , its officers, directors and agents, and the Archdiocese 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

MEDICAL HISTORY FORM

Student Name: _____ Date of Birth: _____

The Medical History Form is part of the Athletic Physical and must be presented to the physician at the time of the physical examination. Explain any "Yes" answers at end of the form. Circle questions for which you don't know the answers.

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

1.	Have you had a medical illness or injury since your last checkup 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, non-prescription (over-the-counter) medication or using an inhaler?	Yes No
4.	Do you have any allergies (ie: pollen, medicine, food, 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?	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 syndrome, Marfan's syndrome, or abnormal heart rhythm?	Yes No
	Have you had a severe viral infection (ie: 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 (ie: itching, rashes, acne, warts, fungus, 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? If yes, how many times? When was the last concussion? How severe was each one?	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 (ie: knee brace, special neck roll, foot orthotics, retainer for 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 _____ Chickenpox _____

17. Are you currently under a doctor's care?

FOR FEMALES ONLY:

18. When was your first menstrual period? _____
    What 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: _____

I have reviewed and acknowledge the information in this Medical History Form.

Physician's or Authorized Examiner's Signature: _____ 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			
Lymph Nodes			
Heart-Auscultation of the heart in the supine			
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			

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:_____