

PARENT/GUARDIAN AND STUDENT ATHLETIC CONSENT / RELEASE FORM

Student Name _____

(Please print)

Part A: Parent/Guardian Permission to Participate

I hereby give my permission for the above named student to engage in C.I.A.C. or East Catholic High School approved interscholastic athletic activities as a representative of his/her school. I also give consent for the above named student to accompany the team or group as a member on its out-of-town trips. I understand that in the event of injury, reasonable action will be taken by the school or its agent to secure appropriate medical care, as indicated in Part C below. In such event, my insurance coverage will be the primary insurance for such provided care. I understand that there is a supplemental policy provided by the school through the IS/IT [Independent School Insurance Trust].

Part B: Parent/Guardian & Student Rule Awareness Verification

I have read and understand the rules, regulations, policies, and responsibilities as stated in the Student Activities Handbook of East Catholic High School, and in the C.I.A.C. Rules and Regulations, and the penalties for violation of either. I understand and accept these rules, regulations, policies, and accompanying penalties as condition for participation. My student is also aware of the above, and agrees to comply.

Part C: Parent/Guardian Medical Consent

I hereby give my consent, in the event of injury or illness, for emergency medical treatment, hospitalization, or other medical treatment as may be necessary for the welfare of the above named student, by a physician, qualified nurse, certified athletic trainer, and/or hospital during all periods of time in which the student is away from his/her legal residence as a member of an interscholastic activity team or group. Further, I hereby waive, on behalf of myself and the above named student, any liability of East Catholic High School, the Office of Catholic Schools, the Archdiocese of Hartford, its agents, or employees, arising out of such medical treatment.

Part D: Parent/Guardian & Student Risk Awareness Verification

I understand and acknowledge that organized high school athletics involve the potential for injury which is inherent in all sports. I acknowledge that even with the best coaching, use of the most advanced protective equipment, and strict observance of rules and regulations, injuries are still a possibility. On rare occasions, these injuries can be so severe as to result in total disability, paralysis, or even death.

* * * * *

We the undersigned, acknowledge that we have read and understand all aspects of this form, including Parts A, B, C, & D, and grant permission and consent as required.

Parent/Guardian Signature

Date

Student Signature

Date

Work phone _____

Home phone _____

Emergency Contact _____

Phone _____

Medical insurance:

Carrier: _____

Policy number: _____

EAST CATHOLIC HIGH SCHOOL SPORTS PARTICIPATION HEALTH FORM

This evaluation is only to determine readiness for sports participation. It should not be used as a substitute for regular health maintenance examinations. *THIS PART MUST BE COMPLETED BY PARENT & STUDENT BEFORE BEING BROUGHT TO THE DOCTOR'S OFFICE.*

NAME _____ AGE _____ SEX _____ SCHOOL _____
 ADDRESS _____ PHONE _____ GRADE _____
 SPORTS BEING PLAYED (1) _____ (2) _____ (3) _____

MEDICAL HISTORY

(To be completed by student and parent or guardian)

1. Do you have any allergies? (Drugs, Foods, Insect Stings, etc.)
 _____ Yes; list: _____ No
2. Are you currently taking any drugs or medications including steroids or protein supplements? (Daily or occasionally)
 _____ Yes; list: _____ No
3. Are you presently being treated for any condition by a physician or other health care professional?
 _____ Yes; explain: _____ No
4. Have you ever been advised by a doctor not to participate in any sport?
 _____ Yes; explain: _____ No
5. Do you have any chronic conditions, disorders or diseases? Check those applicable or..... No
 _____ Asthma _____ Bleeding Disorders _____ Diabetes _____ Epilepsy (Seizures)
 _____ Hepatitis (liver disease) _____ Hypertension(High Blood Pressure) _____ Sickle Cell Anemia _____ (Other) _____
 _____ Mononucleosis-Yr _____ _____ Kawasaki's Disease _____ Handicap (Describe) _____

Please check where applicable if you have or have had any of the following:

	YES	NO		YES	NO
Head injury, concussion, or been unconscious	_____	_____	Eye injury or retinal detachment	_____	_____
If yes, how many times _____	_____	_____	Blurred vision or vision in one eye only	_____	_____
Headaches more than once a week	_____	_____	Wear glasses or contact lenses	_____	_____
Lack of feeling or numbness in any part of the body	_____	_____	Hearing loss or impairment in one or both ears	_____	_____
Heat exhaustion or heat stroke	_____	_____	Tubes in ears or a perforated eardrum	_____	_____
Difficulty running 1/2 mile without stopping	_____	_____	False teeth, caps or braces	_____	_____
Chest pain, dizziness or passing out during exercise	_____	_____	Nose bleeds for no reason	_____	_____
Coughing, wheezing or gasping for breath	_____	_____	Bruising easily or taking a long time to	_____	_____
with exercise or cold weather	_____	_____	stop bleeding when cut	_____	_____
Smoke cigarettes or chew tobacco	_____	_____	Diarrhea more than once a week	_____	_____
Heart problem, murmur or arrhythmia	_____	_____	Black or bloody bowel movements (stools)	_____	_____
Family member with a heart attack under age 50	_____	_____	Kidney disease or dark, brown or bloody urine	_____	_____
Loss or gain of more than 10 lbs. in last year	_____	_____	Less than two kidneys or, in males, two testicles	_____	_____
Special diet for medical reasons	_____	_____	Lump(s) in arm pit or groin	_____	_____
<i>For female participants:</i>			Rash or skin problems	_____	_____
Absent or irregular monthly periods	_____	_____	Neck, spine or low back injury or pain	_____	_____
Disabling cramps with your menstrual periods	_____	_____			

Have you ever been hospitalized for medical or surgical reasons?..... YES NO
 If yes, provide the following information: _____

<u>REASON</u>	<u>YEAR</u>	<u>HOSPITAL</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please carefully list below any injury (nerve, muscle, bone or joint) that you have had which did not allow you to participate in regular activity for a week or more?

<u>INJURED AREA</u> (Knee, Hamstring, Neck, Shin, etc.)	<u>YEAR</u>	<u>SIDE</u> (R, L)	<u>HOSPITAL</u> (Fracture, Sprain, Swelling, Pinched Nerve, etc.)	<u>RESOLVED</u> YES	<u>NO</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

STUDENT AND PARENT OR GUARDIAN:
 We hereby state that we have reviewed this medical history and found the information supplied above to be correct to the best of our knowledge.

STUDENT SIGNATURE _____ DATE _____ PARENT OR GUARDIAN SIGNATURE _____ DATE _____

MEDICAL EXAMINATION – To Be Completed By Medical Doctor or his designee

NAME _____ DATE OF BIRTH _____

GENERAL EXAM

	Normal	Abnormal Findings
APPEARANCE		
SKIN		
HEENT		
RESPIRATORY		
CARDIOVASCULAR		
		Arrhythmia
		Murmur
ABDOMEN		
SPINE		
NEUROLOGICAL		
GENITALIA (Hernia)		
PHYSICAL MATURITY (TANNER STAGE)		1 2 3 4 5

HEIGHT _____ WEIGHT _____
 BLOOD PRESSURE _____ PULSE _____
 HCT/HGB _____
 URINALYSIS: _____ Protein _____ Blood _____ Glucose
 VISUAL ACUITY: _____ RIGHT _____ LEFT
 CORRECTED TO: _____ RIGHT _____ LEFT
 HEARING: _____

BODY FAT (optional) = _____ %
 CHOLESTEROL (optional) = _____

LAST TETANUS BOOSTER DATE: _____
 LAST MEASLES (MMR) BOOSTER DATE: _____
 OTHER IMMUNIZATIONS _____ DATE: _____

SUMMARY: _____

ORTHOPEDIC EXAM

MUSCULOSKELETAL EVALUATION TO INCLUDE RANGE OF MOTION, STRENGTH, FLEXIBILITY

	Normal	Abnormal Findings
NECK		
SPINE		
SHOULDERS		
ARMS.HANDS		
HIPS		
THIGHS		
KNEES		
ANKLES		
FEET		

RECOMMENDATIONS

WEIGHT LOSS/GAIN _____
 STRENGTHENING _____
 STRETCHING _____
 CONDITIONING (Endurance) _____

MEDICATIONS _____
 SPECIAL EQUIPMENT _____
 BRACING/TAPING _____

I certify that on this date I have examined this student and that, on the basis of the examination requested by the school authorities and the student's medical history as furnished to me. This is good for the school year of _____ unless voided by any serious injury or accident. If voided, it will be the responsibility of the student to get updated medical information from his/her physician before resuming participation in competitive sports. I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities except those listed below:

 SIGNATURE OF MEDICAL DOCTOR M.D. DATE _____ TELEPHONE _____ MEDICAL DOCTOR (PRINT OR STAMP)