UPDATED 8-12-2017

SAINT PETER THE APOSTLE SCHOOL

Athletic Participation/Parental Consent/Physical Examination Form

Separate examination is required for each school year

For School Year_____

PART I - ATHLETIC PARTICIPATION

(To be filled in and signed by the student)

Male _____
Female _____

Name_____
(Last) (First) (Middle Initial)

Home Address_____

City/Zip Code_____

Home Address of Parents_____

City/Zip Code _____

Date of Birth_____Place of Birth_____

INDIVIDUAL ELIGIBILITY RULES

Attention Athletes! To be eligible to represent your school in any athletic contest you:

- must have achieved a 2.0 grade point average in the semester preceding participation in an activity
- must be in attendance at your school for at least four (4) hours on the day you wish to participate in a practice or contest

Eligibility to participate in interscholastic athletics is a privilege you earn by meeting not only the above-listed minimum standards, but also all other standards set by SPAL and Saint Peter the Apostle. If you have any question regarding your eligibility or are in doubt about the effect an activity might have on your eligibility, **check with your principal for interpretations and exceptions.**

Student Signature:_____ Date:_____

The pre-participation physical examination is not a substitute for a thorough annual examination by a student's primary care physician

PART II - - MEDICAL HISTORY-Explain "Yes" answers below

This form must be completed and signed, prior to the physical examination, for review by examining physician. Explain "Yes" answers below with number of the question. Circle questions you don't know the answers to.

GENERAL MEDICAL HISTORY	Yes	No
1. Has a doctor ever denied or restricted your participation in Sports for any reason?	☐	☐
2. Do you currently have an ongoing medical condition? If so, Please identify: Asthma | Anemia | Diabete ☐ Infections Other.	☐	☐
3. Have you ever spent the night in the hospital?	☐	☐
4. Have you ever had surgery?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?	☐	☐
6. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
7. Does your heart race or skip beats during exercise?	☐	☐
8. Has a doctor ever told you that you have (check all that apply): ☐ High Blood Pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease ☐ Other	☐	☐
9. Has a doctor ever ordered a test for your heart? (for ex: ECG/EKG, echocardiogram)	☐	☐
10. Do you get lightheaded or feel more short of breath than expected during exercise?	☐	☐
11. Have you ever had an unexplained seizure?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
12. Has any family member or relative died of heart problems or had an unexpected sudden death before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)?	☐	☐
13. Does anyone in your family have a heart problem?	☐	☐
14. Does anyone in your family have a pacemaker or implanted defibrillator?	☐	☐
15. Does anyone in your family have Marfan syndrome, cardiomyopathy or Long Q-T?	☐	☐
16. Has anyone in your family had unexplained fainting, unexplained Seizures, or near drowning?	☐	☐
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or game?	☐	☐
18. Have you had any broken or fractured bones or dislocated joints?	☐	☐
19. Have you had a bone or joint injury that required x-rays, MRI, CT, Surgery, injections, rehabilitation, physical therapy, a brace, a cast or crutches?	☐	☐
20. Have you ever had an x-ray or your neck for atlanto-axial Instability? OR have you ever been told that you have that disorder or any neck/spine problem?	☐	☐
21. Have you ever had a stress fracture of a bone?	☐	☐
22. Do you regularly use a brace or assistive device?	☐	☐
23. Do you currently have a bone, muscle, or joint injury that bothers you?	☐	☐
24. Do any of your joints become painful, swollen, feel warm, or look red?	☐	☐
25. Do you have a history of juvenile arthritis or connective tissue disease?	☐	☐
MEDICAL QUESTIONS	**Yes**	**No**
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
27. Do you have asthma or use asthma medicine (inhaler, nebulizer)?	☐	☐
28. Were you born without or are you missing a kidney, an eye, a testicle, spleen or any other organ?	☐	☐

MEDICAL QUESTIONS (cont)	Yes	No
29. Do you have groin pain or a painful bulge or hernia in the groin area?	☐	☐
30. Have you had mononucleosis (mono) within the last month?	☐	☐
31. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
32. Have you ever had a herpes or MRSA skin infection?	☐	☐
33. Are you currently taking any medication on daily basis?	☐	☐
34. Have you ever had a head injury or concussion? If so, date of last injury:	☐	☐
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit of falling?	☐	☐
36. Do you have headaches with exercise?	☐	☐
37. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
38. When exercising in heat, do you have severe muscle cramps or become ill?	☐	☐
39. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
40. Have you had any other blood disorders?	☐	☐
41. Have you had any problem with your eyes or vision?	☐	☐
42. Do you wear glasses or contact lenses?	☐	☐
43. Do you wear protective eyewear, such as goggles or face shield?	☐	☐
44. Do you worry about you weight?	☐	☐
45. Are you trying to or has any professional recommended that you try to gain or lose weight?	☐	☐
46. Do you limit or carefully control what you eat?	☐	☐
47. Do you have any concerns that you would like to discuss with a doctor?	☐	☐
48. What is the date of your last Tetanus immunizations? Date:_____	☐	☐
49. Do you have an allergy to medicine, food, or stinging insects?	☐	☐
FEMALES ONLY		
50. Have you ever had a menstrual period?	☐	☐
51. Age when you had your first menstrual period? _____		
52. How many periods have you had in the last 12 months?		

EXPLAIN "YES" ANSWERS BELOW:

#___>_____

#___>_____

#___>_____

#___>_____

#___>_____

***List medications and nutritional supplements you are currently taking here:**

Parent/Guardian Signature: _____ Date:_____ Athlete's Signature: _____

PART III – PHYSICAL EXAMINATION

(Physical examination is required each school year)

NAME: _____ Date of Birth_____ SCHOOL: _____

EXAMINATION			
Height	Weight	☐ Male	☐ Female
BP /	Resting Pulse	☐	☐

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/ears/nose/throat		
Lymph nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Skin		
Neurologic		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional		

Medical Practitioner to School Staff (please indicate any instruction or recommendations here)

Emergency medications required on-site	☐ Inhaler ☐ Epinephrine ☐ Glucagon ☐ Other

Comments:

I have reviewed the data above, reviewed his/her medical history form and make the following recommendations for his/her participation in athletics.

- ❑ **CLEARED WITHOUT RESTRICTIONS**
- ❑ **CLEARED WITH FOLLOWING NOTATION**: _____
- ❑ Cleared **AFTER** documented further evaluation or treatment for: _____
- ❑ Cleared for **Limited participation** (check and explain "reason" for all that apply): *"Limited Until Date": when appropriate*
  - ❑ Not cleared for (specific sports)_____ Until Date:_____

  Reason(s): _____
- ❑ **NOT CLEARED FOR PARTICIPATION**_____

  Reason(s): _____

By this signature, I attest that I have examined the above student and completed this pre-participation physical including a review of Part II – Medical History.

Provider Signature: _____(MD, DO, NP, PA) Date_____
circle one

Examiner's Name and degree (print): _____Phone Number_____

Address: _____City _____State _____ Zip _____

+Only signature of Doctor of Medicine, Doctor of Osteopathic Medicine, Nurse Practitioner or Physician's Assistant licensed to practice in the United States will be accepted

PART IV -- ACKNOWLEDGEMENT OF RISK AND INSURANCE STATEMENT

(To be completed and signed by parent/guardian)

I give permission for_____(name of child) to participate in any of the following sports that are not crossed out: baseball, basketball, cheerleading, cross country, football, lacrosse, soccer, softball, track, golf, volleyball.

I have reviewed and understand the individual eligibility rules and I am aware that with the participation in sports comes the risk of injury to my child. I understand that the degree of danger and the seriousness of the risk vary significantly from one sport to another with contact sports carrying the higher risk. I have had an opportunity to understand the risk inherent in sports through meetings, written handouts, or some other means. He/she is insured by our family policy with:

Name_____of_____Company:

Policy Number_____Name of Policy Holder_____

By this signature, I hereby consent to allow the physician(s) and other health care provider(s) selected by myself or the school to perform a pre-participation examination on my child and to provide treatment for any injury or condition resulting from participating in athletics/activities for his/her school during the school year covered by this form. I further consent to allow said physician(s) or health care provider(s) to share appropriate information concerning my child that is relevant to participation in athletics and activities with coaches and other school personnel as deemed necessary.

Additionally I give my consent and approval that the above named student's picture and name may be printed in SPAL or Saint Peter the Apostle athletic program, publication or video.

PART V - EMERGENCY PERMISSION FORM

(To be completed and signed by parent/guardian)

STUDENT'S NAME _____GRADE_____AGE_____

Please list any significant health problems that might be significant to a physician evaluating your child in case of an emergency _____

_____

_____

Please list any allergies to medications, etc._____

_____

Has student been prescribed an inhaler or epipen?_____

Is student presently taking medication?_____If so, what type?_____

Does student wear contact lenses?_____ Please list date of last tetanus shot_____

*Daytime phone number (where to reach you in emergency)_____

*Evening time phone number (where to reach you in emergency)_____

* Please make sure phone numbers are current for the duration of participation

Signature of parent or guardian_____Date_____

Relationship to student _____