

NAME: _____		Sex: _____		Grade: _____		Sport: _____	
Last	First	MI	D.O.B.				
ADDRESS: _____							
Street			City	State		Zip	
MOTHER: _____				FATHER: _____			
Telephone Home: _____				Telephone Home: _____			
Cell: _____				Cell: _____			
Work: _____				Work: _____			
Email: _____				Email: _____			
Parent or Guardian whom child resides with primarily:				Mother <input type="checkbox"/> Father <input type="checkbox"/> Both <input type="checkbox"/> Other <input type="checkbox"/>			
STUDENT HEALTH INSURANCE PROVIDER				EMERGENCY CONTACT PERSON (other than parents)			
Name of Company _____				NAME: _____			
Policy Number _____				Telephone Home: _____			
Group Number _____				Cell Phone: _____			

This section is to be completed by parent or legal guardian.

GENERAL MEDICAL HISTORY	YES	NO
1. Does your child have any ongoing medical condition currently? If YES, please explain:	<input type="checkbox"/>	<input type="checkbox"/>
2. Has your child been advised by a physician NOT to participate in any activity (SPORTS) within the last 12 months? If YES, please describe and give date(s).	<input type="checkbox"/>	<input type="checkbox"/>
3. To the best of your knowledge, has your child had any problems with the following?		

	YES	NO	COMMENT		YES	NO	COMMENT
Allergies: medicine	<input type="checkbox"/>	<input type="checkbox"/>		Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies: food	<input type="checkbox"/>	<input type="checkbox"/>		Hernia	<input type="checkbox"/>	<input type="checkbox"/>	
Anaphylaxis	<input type="checkbox"/>	<input type="checkbox"/>		Hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	
Anemia	<input type="checkbox"/>	<input type="checkbox"/>		Learning Disabilities	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	
Behavior/Emotional	<input type="checkbox"/>	<input type="checkbox"/>		Migraines	<input type="checkbox"/>	<input type="checkbox"/>	
Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>		Nasal Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>		Physical Disabilities	<input type="checkbox"/>	<input type="checkbox"/>	
Dental	<input type="checkbox"/>	<input type="checkbox"/>		Prematurity	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Ear Problem/Deafness	<input type="checkbox"/>	<input type="checkbox"/>		Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Eye or Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>		Speech Problems	<input type="checkbox"/>	<input type="checkbox"/>	
GI Problems	<input type="checkbox"/>	<input type="checkbox"/>		Surgery	<input type="checkbox"/>	<input type="checkbox"/>	
GU Problems	<input type="checkbox"/>	<input type="checkbox"/>		Throat	<input type="checkbox"/>	<input type="checkbox"/>	
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>		Other	<input type="checkbox"/>	<input type="checkbox"/>	

GENERAL MEDICAL HISTORY <i>Continued</i>	YES	NO
4. Has your child ever had one of the following? <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Hepatitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Other infectious disease? _____	<input type="checkbox"/>	<input type="checkbox"/>
5. Does your child have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
6. Is your child missing a kidney, eye, testicle, or other organ? _____	<input type="checkbox"/>	<input type="checkbox"/>
7. Does your child bruise easily?	<input type="checkbox"/>	<input type="checkbox"/>
8. Does your child have or have they ever had (Check all that apply): <input type="checkbox"/> Hearing loss <input type="checkbox"/> Perforated Ear Drum <input type="checkbox"/> Recurrent Ear Infections <input type="checkbox"/> Different Eye color <input type="checkbox"/> Unequal Pupils <input type="checkbox"/> Sinus Infection <input type="checkbox"/> Fracture/Broken Nose <input type="checkbox"/> Loose or Broken Teeth/ Dental Implants	<input type="checkbox"/>	<input type="checkbox"/>
9. Does your child have impaired vision (other than wearing glasses) in: LEFT EYE RIGHT EYE	<input type="checkbox"/>	<input type="checkbox"/>

MEDICATION	YES	NO
10. Does your child take Medications regularly? If YES, please list and explain for what use:	<input type="checkbox"/>	<input type="checkbox"/>
11. Does your child take MEDICATIONS for EMERGENCY USE? If YES, please list:	<input type="checkbox"/>	<input type="checkbox"/>
12. IS YOUR CHILD ALLERGIC TO ANY MEDICATIONS? If YES, please list:	<input type="checkbox"/>	<input type="checkbox"/>
FAMILY HISTORY	YES	NO
13. Has anyone in your immediate family had or have: <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Anemia <input type="checkbox"/> Migraines <input type="checkbox"/> Kidney Problems <input type="checkbox"/> Epilepsy <input type="checkbox"/> High Blood Pressure If checked, state relation to student (parent, sibling, and aunt/uncle): _____	<input type="checkbox"/>	<input type="checkbox"/>
14. Has a family member or relative died of heart problems or sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>
15. Has your child been diagnosed OR has anyone in your family been diagnosed with Marfan's syndrome?	<input type="checkbox"/>	<input type="checkbox"/>
16. Does your child have the SICKLE CELL TRAIT or SICKLE CELL DISEASE? Specify which _____	<input type="checkbox"/>	<input type="checkbox"/>
CARDIOVASCULAR/RESPIRATORY	YES	NO
17. Has a doctor ever told you that your child has: (check all that apply) <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Enlarged Heart <input type="checkbox"/> Heart Infection <input type="checkbox"/> High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
18. Has your child ever passed out or nearly passed out DURING or AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>
19. Has your child ever had discomfort, pain, pressure, or rapid heartbeat during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
20. Has your child ever used an inhaler or taken asthma medication? If yes what medication: _____	<input type="checkbox"/>	<input type="checkbox"/>
21. Does your child cough, wheeze, have shortness of breath or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
HEAT PROBLEMS	YES	NO
22. Has your child ever had problems with exercising in heat or hot weather?	<input type="checkbox"/>	<input type="checkbox"/>
23. When exercising in the heat, does your child ever have severe muscle cramps?	<input type="checkbox"/>	<input type="checkbox"/>
24. Has your child had episodes of Heat Illness, Dehydration, Heat Exhaustion, or Heat Stroke? If YES explain/Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>
ORTHOPEDIC	YES	NO
25. Has your child ever had a muscle strain or sprain, pull or tear? If YES specify body part(s): _____	<input type="checkbox"/>	<input type="checkbox"/>
26. Has your child broken, fractured or dislocated any bones? If YES specify body part(s): _____	<input type="checkbox"/>	<input type="checkbox"/>
27. Has your child had problems with pain or swelling in muscles, tendons, bones or joints? If YES specify body part(s): _____	<input type="checkbox"/>	<input type="checkbox"/>
HEAD & NECK PROBLEMS	YES	NO
28. Has your child ever been diagnosed with a HEAD INJURY / CONCUSSION (Mild Traumatic Brain Injury) by a Medical Professional (MD, DO, PA, Athletic Trainer, Nurse)?	<input type="checkbox"/>	<input type="checkbox"/>
IF YES: - How many concussions has your child had?		
- Please list date of most recent concussion:		
29. Has your child been hit in the head and been confused or lost memory or lost consciousness?	<input type="checkbox"/>	<input type="checkbox"/>
30. Has your child ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
31. Has your child been diagnosed with Epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>
32. Does your child have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
33. Has your child ever had temporary loss of vision after being hit in the head or falling?	<input type="checkbox"/>	<input type="checkbox"/>
34. Has your child ever had a neck injury?	<input type="checkbox"/>	<input type="checkbox"/>
35. Has your child ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
36. Has your child ever been unable to move his/her arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
Please explain any additional important medical information the medical staff at Archbishop Curley High School should be aware of (i.e. surgeries, illnesses, conditions, etc....)		

NAME: _____ **GRADE:** _____ **SPORT:** _____

BY SIGNING BELOW, I/WE CERTIFY THAT:

I. PARENTAL CONSENT TO TREAT:

- A. Permission is hereby granted to the Archbishop Curley High School Certified: Athletic Trainers, Nurses, Faculty and Coaches to proceed with any necessary Primary and Secondary First Aid. In the event of serious illness or injury I understand that an attempt will be made to contact me in the most expeditious manner possible. If in the event I cannot be reached, the treatment or referral necessary for the best interest of the above-named participant will be given.
- B. Permission is hereby granted to the Archbishop Curley High School Certified/Licensed Athletic Trainers to proceed with any necessary evaluation, minor medical treatment, and/or rehabilitation of injuries for the above-named student/athlete.
- C. Permission is hereby granted to the Archbishop Curley High School Certified/Licensed Athletic Trainers to proceed with any necessary use of modalities (including but not limited to: Moist Heat, Ultrasound, Electric Stimulation, T.E.N.S, Light Therapy, Paraffin Bath, Compression Unit, Whirlpools) for the care, treatment and rehabilitation for the above-named student/athlete's injury(s). All modalities will be used under the direction of the Archbishop Curley High School Team physician and/or other referring physicians and will only be administered by the Archbishop Curley High School Certified Athletic Trainers.
- D. XLNTbrain Testing: Permission is granted for the above named student-athlete to participate in completing a Baseline XLNTbrain test. The baseline will be stored in a database for later use should the athlete sustain a head injury, concussion or mild traumatic brain injury (MTBI).

II. CONSENT TO RECEIVE MEDICATION:

Permission is hereby granted to the Archbishop Curley High School Certified Athletic Trainers to distribute medication/topical substances (listed below) to the above-named student athlete. Please indicate if your son **SHOULD NOT** have any of the following medications.

Acetaminophen(Tylenol or generic- 500mg)	Gold Bond Powder	New Skin Liquid Bandage
Aleve(220mg)	Medi-Lyte / Heat Aid *	Non-Pseudo Sinus Decongestant**
Bacitracin	Hydrocortisone 1.0%, 2.0%,	Pepto Bismol (or generic equivalent)
Benadryl (or generic equivalent) 25mg	Hydrogen Peroxide	Sterile Saline Solution
Betadine Solution (Providone-iodine 10%)	Lotrimin 1%	Tuffskin (Tape Adherent Spray)
Biofreeze (analgesic)	Ibuprofen (generic) 200mg	Tums
Cough Drops (Halls or generic equivalent)	Isopropyl Alcohol	Zinc Oxide Ointment

*Electrolyte Supplement **Phenylephrine HCL 10mg

The above-named student SHOULD NOT take /is allergic to the following: _____

III. PARENTAL AUTHORIZATION FOR THE USE & DISCLOSURE OF MEDICAL INFORMATION (HIPAA & FERPA):

I hereby authorize the Sports Medicine Staff (Athletic Trainers and Team Physicians) and School Nurses to share appropriate information (medical and/or other) concerning my child that is relevant to participation in school, activities and athletics with administrators, nurses, counselors, coaches, other healthcare professionals (as determined by parent). I understand that I may revoke this authorization at any time. However, the revocation will not apply to information that has already been released. I understand that I must do any revocation in writing and present my written revocation to the Sports Medicine Staff. Unless revoked, this authorization is in effect for the entire school year.

IV. STATEMENT CONCERNING TRANSPORTATION:

I understand when Archbishop Curley High School does not provide bus or van transportation; my child will be responsible for arranging his/her own means. I do not hold Archbishop Curley High School or its faculty or staff responsible for any problems that may arise from these personal transportation arrangements.

V. STATEMENT OF RISK:

I acknowledge that Archbishop Curley High School assumes no responsibility for any risks associated with voluntary participation in school organized athletic, physical education or other activities. Furthermore, I understand that these sports activities involve risk of serious injury or death. After weighing these risks against the potential benefits my son/daughter may gain from these activities, I freely and fully accept the risks of athletics on my child's behalf.

VI. STATEMENT OF LIABILITY:

In exchange for the opportunity to participate in interscholastic athletics, I freely and fully waive any claim by me, my spouse or my child, against Archbishop Curley High School and its employees arising from a sports related injury or from transportation to/from a sporting event.

Additionally, Archbishop Curley High School's certified athletic trainers and administrators reserve the right to make final decisions regarding a student-athletes participation status with interscholastic athletics.

By signing below I/we certify that: I/we are in agreement with the statements/authorizations made above, the answers to the questions are true and correct and that I/we understand that having passed the physical examination does not necessarily mean that my child is physically qualified to engage in athletics but only that the examiner did not find medical reason to disqualify him/her at the time of said examination.

PARENT / GUARDIAN SIGNATURE

DATE

TO BE COMPLETED BY PHYSICIAN

NAME: _____ D.O.B.: _____ Grade: _____ Sport(s): _____

1. **MEDICAL CONDITION: Does the child have a *diagnosed* medical condition?** YES NO
 (e.g., seizure, insect sting allergy, asthma, bleeding problem, diabetes, heart problem, other). Specify: _____

2. **If YES does the condition require EMERGENCY ACTION while he/she is at school or athletic activities?** Please describe necessary actions or indicators for condition.

3. **SICKLE CELL: Has this individual been tested for *SICKLE CELL*?** YES NO Date: _____
 IF YES please indicate the results: NEGATIVE POSITIVE POSITIVE TRAIT

4. **Is the child on regular medication?** YES NO
 IF YES - Name of Medication(s) - _____

5. **Date of most recent TETANUS immunization:** _____

Height: _____ Weight: _____ BP: _____ Pulse: _____ Vision ____/ 20__

GENERAL MEDICAL	WNL	Abnormal
General Appearance		
Skin		
E N T		
Dental		
Lymph Nodes		
Chest		
Heart/Cardiac		
Lungs		
Abdomen		
Hernias		
Endocrine		
Other		

MUSCULOSKELETAL	WNL	Abnormal
Spine (Neck/Back)		
Shoulders		
Arms / Elbow		
Elbows		
Hands/Wrists		
Hips		
Legs		
Knees		
Ankles		
Feet		
Neurological/Sensory		
Other		

HEALTH AREA CONCERN	WNL	Abnormal
ADD / ADHD		
Behavior/Adjustment		
Psychosocial		
Development		
Hearing		
Immunodeficiency		
Lead Exposure/Elevated Lead		
Learning Disabilities/Problems		
Nutrition		
GI / GU		
Speech/Language		
Other		

REMARKS: (Please explain any abnormal findings/health concerns or other medical issues that the health staff need to be aware of)

CLEARED FOR ALL PHYSICAL ACTIVITY

NOT CLEARED - REASON: _____
Note, should the above named individual have any restrictions, a letter from the individual's physician must accompany this form explaining any and all medical conditions as well as indicate restrictions and level of participation. Archbishop Curley High School reserves the right to make final decisions as to the above named individual's status regarding participation in interscholastic athletics for Archbishop Curley High School.

I certify that I have on this date 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, I have found no reason which would make it inadvisable for this student to compete in supervised athletic activities.

 Examiner Name (Print or Type) Examiner Signature DATE

 Address Street Telephone Number

 City State Zip

If the Physician's Assistant or Nurse Practitioner performed exam, please give the Name & Address of collaborating physician/group