

Providence Catholic School - Athletics

Use only BLACK or BLUE ink to complete – PRINT all information.

School Year: _____

Grade: _____

Sports (please check all that apply): Cross Country Volleyball Basketball Soccer Softball Track Swim
 Tennis Golf Bowling Dance Band ROTC

Student Contact Information

Student's Full Name: _____ DOB: _____ Age: _____

Social Security #: _____ Home Phone #: _____

Address: _____ City, Zip: _____

Mother / Guardian Name: _____ Cell Phone #: _____ Work #: _____

Father / Guardian Name: _____ Cell Phone #: _____ Work #: _____

IF PARENTS CANNOT BE REACHED IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name: _____ Relationship to Student: _____

Home Phone #: _____ Cell Phone #: _____ Work #: _____

Medical Contact Information

Family Doctor or Clinic: _____ Phone #: _____

Family Dentist or Clinic: _____ Phone #: _____

Preferred Hospital: _____

List all medications taken regularly and why: _____

List all known allergies: _____

Medical Insurance Information

All athletes must be covered under some form of health insurance or the parent must sign a waiver of responsibility. Please indicate below which form of coverage you will be using:

_____ MILITARY COVERAGE

Sponsor Name: _____ Branch of Service: _____

Sponsor DOB: _____ Sponsor SS #: _____

_____ INDIVIDUAL OR GROUP MEDICAL- We are covered under our own group or individual major medical health insurance policy which provides benefits for our daughter.

Insurance Co.: _____ HMO: _____ PPO: _____

Address: _____ Phone #: _____

Insured's Name: _____ Insured's Employer: _____

Insured's DOB: _____ Insured's SS #: _____

Group #: _____ Policy #: _____

Waiver of Liability

It is understood that even though protective equipment is worn by the athlete, whenever needed, the possibility of an accident still remains. Neither the Texas Association of Private and Parochial Schools nor Providence Catholic School assumes any responsibility in case an accident occurs.

If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or illness, I do hereby request, authorize and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school, TAPPS, and any school or hospital representative from any claim by any person on account of such care and treatment of said student.

We agree to accept full responsibility for all medical expenses incurred by our daughter while participating in the Providence Catholic School athletic program. We hereby release Providence Catholic School, its coaches, teachers and administrators from any and all liability as a result of athletic-related injuries

Parent / Guardian Signature: _____ Date: _____

Form completed in its entirety must be completed and signed by parent / guardian and returned to the Athletic Director or Head Coach before your daughter may participate in sports at Providence Catholic School.

A photocopy of this authorization shall be considered as effective and valid as the original.

Providence Catholic School - Athletics

Medical History

Student Name: _____ Date of Birth: _____

The Medical History AND Physical Examination Forms must be completed *annually* by a parent/guardian and student in order for the student to participate in athletic activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an athletic event.

Explain any "YES" answers on a separate piece of paper. Please circle questions for which you have no answer. Any "YES" answer to questions 1- 28 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physicians assistant, chiropractor or nurse practitioner is required before any participation in **TAPPS** practices, games or matches.

	Yes	No		Yes	No
1. Have you had a medical illness or injury since your last checkup or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>	29. Have you ever been dizzy before or during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been hospitalized overnight in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	30. Do you currently have any skin problems (itching, acne, warts, fungus or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	31. Have you ever become ill after exercising or working in the heat?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	32. Have you ever had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	33. Have you ever gotten unexpectedly short of breath with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you get tired more quickly than your friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	34. Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever experienced racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	35. Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	36. Do you use any special protective or corrective equipment?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever had high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	37. Have you ever had a sprain, strain or swelling after injury?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	38. Have you ever broken or fractured any bones?	<input type="checkbox"/>	<input type="checkbox"/>
11. Has any family member or relative died of heart problems before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	39. Have you ever dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>
12. Has any family member or relative died of sudden unexpected death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	40. Have you ever had any problems with pain or swelling in muscles, tendons, bones or joints?	<input type="checkbox"/>	<input type="checkbox"/>
13. Has any family member been diagnosed with enlarged heart (Dilated Cardiomyopathy)?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please check the appropriate box and explain on separate sheet of paper.		
14. Has any family member been diagnosed with Hypertonic Cardiomyopathy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip
15. Has any family member been diagnosed with Long QT Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh
16. Has any family member been diagnosed with ion channelopathy (Brugada syndrome, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Knee
17. Has any family member been diagnosed with Marfan's syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Shin/Calf
18. Have you had a severe viral infection (myocarditis, mononucleosis, etc) in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger	<input type="checkbox"/> Ankle
19. Has a physician ever denied or restricted your participation in sports for any heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Foot	<input type="checkbox"/>
20. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	41. Do you want to weigh more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you ever been knocked out, become unconscious or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	42. Do you lose weight regularly to meet weight requirements for you Extra-Curricular Activities?	<input type="checkbox"/>	<input type="checkbox"/>
22. Have you ever experienced a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	43. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
23. Have you ever had numbness in your arms, hands, legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>	44. Have you been diagnosed with or treated for Sickle Cell Trait or Sickle Cell Disease?	<input type="checkbox"/>	<input type="checkbox"/>
24. Have you ever had a stinger, burner or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	45. When was your first menstrual period?		
25. Are you missing any paired organs?	<input type="checkbox"/>	<input type="checkbox"/>	46. When was your most recent menstrual period?		
26. Are you presently under a doctor's care?	<input type="checkbox"/>	<input type="checkbox"/>	47. How much time elapses from the start of one period to the start of another? _____days		
27. Are you currently taking any prescription or nonprescription medications or inhalers?	<input type="checkbox"/>	<input type="checkbox"/>	48. How many periods have you had in the last year?		
28. Do you have any allergies?	<input type="checkbox"/>	<input type="checkbox"/>	49. What was the longest time between periods in the last year? _____days		

If between this date and the beginning of athletic competition, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury. I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. *Failure to provide truthful and complete responses could subject the student in question to penalties determined by the Texas Association of Private and Parochial Schools.*

Parent / Guardian Signature _____ Student Signature _____ Date _____

This Medical History Form reviewed by (school use only) Name: _____ Date: _____

Providence Catholic School - Athletics Physical Examination

Student Name: _____ DOB: _____ Age: _____ Grade: _____

 Height: _____ Weight: _____ Pulse: _____ BP: _____ / _____ (_____/_____, ____/____)

Vision: R 20 / _____ L 20 / _____ Corrected: Y / N Pupils: Equal / Unequal

In keeping with the requirements of the Texas Association of Private and Parochial Schools, as a minimum requirement, this **PHYSICAL EXAMINATION FORM** must be completed prior to high school athletic participation each year of high school. This form must be completed if there are yes answers to specific questions on the student's annual **MEDICAL HISTORY FORM**.

GENERAL ANATOMY

	Normal	Abnormal Findings	Initials
Appearance			
Eyes / Ears / Nose / Throat			
Lymph Nodes			
Auscultation of the heart- Supine			
Auscultation of the heart- Sitting			
Pulses			
Lungs			
Abdomen			
Skin			
Liver / Spleen			
Spine			

MUSCULOSKELETAL

	Normal	Abnormal Findings	Initials
Neck			
Back			
Shoulder / Arm			
Elbow / Forearm			
Wrists / Hands			
Hips / Thighs			
Knees			
Legs / Ankles			
Feet			

CLEARANCE

____ Cleared for all sports
 ____ Cleared after completing evaluation / rehabilitation for: _____

Must be cleared by: Dr. _____

____ Not cleared for: (sports) _____ Reason: _____

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 Practice Nurse by the Board of Nurse Examiners.

Printed/Typed/Stamped Name: _____

Address: _____ Phone #: _____

Signature: _____ Date of Exam: _____

Physical must be completed before a student participates in any practice (both in-season and out-of-season) or games / matches.

To Be Completed By Parent and Physician

Archdiocese of San Antonio
Catholic Schools Office
MEDICATION PERMISSION REQUEST FORM

According to the policies of the Archdiocese of San Antonio, students are not allowed to carry medication on their person, including non-prescription medications. (The only exception is that, by physician direction, a student may be allowed to carry and self-administer inhaler medication). Medications will be maintained and dispensed by appointed school health coordinators. The following steps must be taken before a student is allowed to take medication at school:

1. Parent/guardian must present this completed consent form to the school.
2. Parent/guardian must bring the medication in the original prescription bottle, properly labeled by a registered pharmacist as prescribed by law.

Medication may be given by the school personnel that the prescribing health care provider completes this form.

Name of Student: _____ Grade: _____

Date of Birth: _____ School: _____

TO BE COMPLETED BY HEALTH CARE PROVIDER

Medication #1	Name	Strength	Dose	Time (at school)	Route
Medication #2	Name	Strength	Dose	Time (at school)	Route
Medication #3	Name	Strength	Dose	Time (at school)	Route

Allergies: _____

Special Instructions: _____

Printed Name of Health Care Provider _____ Signature of Health Care Provider _____ Date _____

TO BE COMPLETED BY PARENT/GUARDIAN

I, _____, request that my child be given the above medication as directed.
(Printed Name)

Signature of parent/guardian: _____ Date: _____

Telephone #: (Home) _____ (Work) _____ (Mobile) _____