



SCHOOL YEAR

Form with fields for NAME, ADDRESS, PARENT(s)/GUARDIAN, MOTHER, FATHER, STUDENT HEALTH INSURANCE PROVIDER, EMERGENCY CONTACT PERSON, and Grade (9-12).

This section is to be carefully completed by the student parent(s) or legal guardian before participation in interscholastic athletics in order to help detect possible risks.

- Family Medical History: 1. Have you had any injuries since your last physical? 2. Do you have an ongoing medical condition? 3. Has anyone in your immediate family had or have: Diabetes, Asthma, High Blood Pressure, Convulsions, Epilepsy, Migraine Headaches... 4. Has a family member or relative died of heart problems or sudden death before age 50? 5. Does anyone in your family have Marfan syndrome? 6. Has a doctor told you that you or someone in your family has SICKLE Cell trait or SICKLE Cell disease? Cardiovascular: 7. Have you ever passed out or nearly passed out DURING exercise? 8. Have you ever passed out or nearly passed out AFTER exercise? 9. Have you ever had discomfort, pain, or pressure in your chest during exercise? 10. Does your heart race or skip beats during exercise? 11. Has a doctor ever told you that you have: High Blood Pressure, A Heart Murmur, High Cholesterol, A Heart Infection... 12. Do you have a tendency to bruise easily? 13. Do you have (check all that apply) Asthma, Diabetes, Anemia, Hernia, Kidney Problems, Blood in Urine... 14. Were you born without or are you missing a kidney an eye, a testicle, or any other organ? Infections/Illnesses: 20. Do you have or have you ever had one of the following? Mononucleosis, Hepatitis, HIV or AIDS, Other infectious disease? 21. Do you have any rashes, pressure sores, or other skin problems? Respiratory: 17. Do you have or have you ever had: Hearing loss?, Perforated Ear Drum?, Recurrent Ear Infections?, Sinus Infection?, Fracture/Broken Nose?, Loose or Broken Teeth, Dental Implants? 18. Is there anyone in your family who has asthma? 19. Do you cough, wheeze, or have difficulty breathing during exercise or after exercise? 20. Do you frequently suffer from shortness of breath? 21. Do you frequently have problem of with hyperventilating? 22. Have you ever used an inhaler or taken asthma medication? Heat Problems: 23. Have you ever had problems with exercising in heat or hot weather? 24. When exercising in the heat, do you have severe muscle cramps, or become ill? 25. Have you had episodes of Heat Illness, Dehydration, Heat Exhaustion, Heat Stroke? If yes please explain: Medications: 26. Do you take Medications regularly? If YES, please list: 27. Do you take Medications for EMERGENCY USE? If YES, please list: 28. Are you ALLERGIC to any MEDICATIONS? If YES, please list: 29. Are you ALLERGIC TO INSECT BITES? Specify:

Orthopedic:

- | | <u>YES</u> | <u>NO</u> |
|--|--------------------------|--------------------------|
| 30. Have you ever had a strain or sprain, muscle pull or tear? | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Have you broken, fractured or dislocated any bones? | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Have you had any problems with pain or swelling in muscles, tendons, bones or joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. 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? | <input type="checkbox"/> | <input type="checkbox"/> |

Check the appropriate box for yes answers to the above questions and explain!

- | | | | | |
|--------------------------------|------------------------------------|---------------------------------|--------------------------------|------------------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> Upper Arm | <input type="checkbox"/> Wrist | <input type="checkbox"/> Hip | <input type="checkbox"/> Shin/Calf |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Hand | <input type="checkbox"/> Thigh | <input type="checkbox"/> Ankle |
| <input type="checkbox"/> Back | <input type="checkbox"/> Elbow | <input type="checkbox"/> Finger | <input type="checkbox"/> Knee | <input type="checkbox"/> Foot |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Forearm | | | |

Explain YES answers:

Head & Neck Injuries:

- | | | |
|--|--------------------------|--------------------------|
| 34. Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> |
| If YES | | |
| a. Was it necessary to be evacuated to a hospital emergency room? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Did you see your family physician for this injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Have you been hit in the head and been confused or lost your memory? | <input type="checkbox"/> | <input type="checkbox"/> |
| List any other symptoms you experienced as well: _____ | | |
| 36. Have you ever had a seizure or do you have Epilepsy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 37. Do you have headaches with exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 38. Have you ever had temporary loss of vision after being hit in the head or falling? | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. Do you have impaired vision in: <input type="checkbox"/> LEFT EYE <input type="checkbox"/> RIGHT EYE | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. Have you ever had a neck injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| 41. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | <input type="checkbox"/> | <input type="checkbox"/> |
| 42. Have you ever been unable to move your arms or legs after being hit or falling? | <input type="checkbox"/> | <input type="checkbox"/> |
| 43. Have you had any illness requiring a physician's services since your last physical for participation in athletics? If YES, please describe and give the date. | <input type="checkbox"/> | <input type="checkbox"/> |
| 44. Have you been advised by a physician NOT to participate in any activity with in the last 12 months? If YES, please describe and give date(s). | <input type="checkbox"/> | <input type="checkbox"/> |
| 45. Please note any other medical conditions the Sports Medicine Staff should be aware of and/or please give explanations to any questions in which you answered YES . | | |



NAME: _____ D.O.B.: __/__/__ Grade 9 10 11 12 Sport: _____

- Does the child have a diagnosed medical condition?
NO YES _____
- Does the child have a health condition that may require EMERGENCY ACTION while he/she is at school or athletic activities? (e.g., seizure, insect sting allergy, asthma, bleeding problem, diabetes, heart problem, other). If yes please describe.
NO YES _____

- Is the child on regular medication?
NO YES - Name of Medication(s) - _____
- Date of most recent TETANUS immunization: _____

Height: _____ Weight: _____ BP: _____ Pulse: _____

GENERAL MEDICAL	WNL	Abnormal
General Appearance		
Skin		
Ears		
Nose		
Throat		
Lymph Nodes		
Chest		
Heart		
Lungs		
Abdomen		
Hernias		
Sensory		

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

CLEARED

Cleared **AFTER** completing evaluation/rehabilitation for: _____

NOT CLEARED for: _____ Reason: _____

Recommendations: _____

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. (Note exceptions above)

Examiner Name (Print or Type)

Examiner Signature

DATE

Address Street

Telephone Number

City State Zip

If the Physician's Assistant (P.A.) or Advance Nurse Practitioner (A.P.N.) performed the exam, please give the Name & Address of collaborating physician or group.



NAME: _____

GRADE: 9 10 11 12

BY SIGNING BELOW, I/WE CERTIFY THAT:

I. PARENTAL CONSENT TO TREAT:

- A. Permission is hereby granted to the Good Counsel High School Certified Athletic Trainers, 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 is given.
- B. Permission is hereby granted to the Good Counsel High School Certified 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 Good Counsel High School Certified Athletic Trainers to proceed with any necessary use of modalities (i.e. Ice, Moist Heat, Ultrasound, Electric Stimulation, T.E.N.S, Light Therapy, Paraffin Bath, Compression Unit, and Whirlpools) for the care, treatment and rehabilitation for the above-named student/athlete's injury(s). All modalities will be used under the orders of the Good Counsel High School Team physician and will only be administered by the Good Counsel High School Certified Athletic Trainers.

II. CONSENT TO RECEIVE MEDICATION:

Permission is hereby granted to the Good Counsel High School Certified Athletic Trainer to distribute medication (listed below) to the above-named student athlete. Please indicate if your son/daughter SHOULD NOT have any of the following medications that are available in the Athletic Training Room for athletes.

Acetaminophen (Tylenol or generic- 500mg)	Cepocol Throat Lozenges	Ibuprofen (generic- 200mg)
Aleve (220mg)	Diamode (Loperamide Hydrochloride- 2mg) **	Magonate Liquid (magnesium- 5ml/ 1Tsp)**
Afrin Nasal Spray (Oxymetazoline Hydrochloride)	Di Gon II (Attapulgit- 600mg)	New Skin Liquid Bandage
Alamag Plus (100mg max 200mg) *	Diphen (Diphenhydramine HCL- 25mg)	Non-Pseudo –Cold Relief *****
Aspirin (325mg)	Diotame (generic Pepto-Bismol)	Sterile Saline Solution
Bacitracin	Gold Bond Powder	Tinactin Athletes Foot Cream/Spray/Powder
Benedryl (25mg)	Heat Aid ****	Tuffskin (Adherent Spray)
Betadine Solution (Providone-iodine 10%)	Hydrocortisone 1.0%, 2.0%, 2.5%	Zinc Oxide Ointment
Biofreeze (analgesic)	Hydrogen Peroxide	

* Generic form of Gas X or Maalox **Antidiarrheal (Imodium) ***Electrolyte Replenisher ****Potassium Chloride, Calcium Phosphate and Magnesium Carbonate (Electrolyte Replenisher) ***** Cold Relief – Acetaminophen, Dextromethorphan(Cough Suppress), Gualfenesin (expectdorant),phenylephrine (decongestant)

The above-named student should NOT take, is allergic to the following: _____

III. PARENTAL AUTHORIZATION FOR THE USE & DISCLOSURE OF MEDICAL INFORMATION:

I hereby authorize the Athletic Training Staff to use and disclose our son/daughter's medical information for purposes related to the evaluation, care, and treatment of athletic-related injuries. I understand that I may revoke this authorization at any time, however the revocation will not apply to information that has already been released in response to this authorization. Should I choose to revoke this authorization, I must do so in writing and present my written revocation to the Athletic Training Staff. Unless otherwise revoked, this authorization will be in effect for the entire school year.

IV. STATEMENT OF RISK:

I acknowledge that Our Lady of Good Counsel 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 or athletics on my child's behalf.

V. 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 Our Lady of Good Counsel High School and its employees arising from a sports related injury or from transportation to/from a sporting event.

VI. STATEMENT CONCERNING TRANSPORTATION:

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

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

Name of Parent/Guardian (Print)

Relation to Athlete