



CATHOLIC GRADE SCHOOL SPORTS CONFERENCE STUDENT ATHLETIC PARTICIPATION APPLICATION

This form is effective from the date indicated on the form, until the end of the current school year. This form must be on file in the School office prior to any student participating in either tryouts or appropriate athletic practice or competition.

Student's Last Name First Middle Initial Application Date

This application to compete in interscholastic athletics for _____ School is entirely voluntary on my part, and is made with the understanding that I have not violated any of the eligibility rules and regulations. _____

Signature of Student

Parent or Guardian's permission: I hereby give my consent for the above student to engage in school approved athletic activities as a representative of his/her school. I agree to allow the above named student to be a passenger in a privately operated vehicle to and from athletic events. I hereby release and discharge the Diocese of St. Augustine, Bishop Felipe Estevez, _____ School, its agents and employees from liability growing out of personal injuries and property damage resulting or occurring during transport to and from said activity.

Date _____ Signature of Parent or Guardian _____

Street Address _____ City _____ Zip _____ Tel. # _____

MEDICAL RELEASE: SIGN THIS SECTION ONLY IN THE PRESENCE OF YOUR NOTARY PUBLIC.

The patient and others, whose signatures appear below, do hereby consent to any and all medical, dental and surgical treatments including anesthesia and operations, which may be deemed advisable by his/her physicians and surgeons as a result of his/her participation in athletic activities. The intention hereof being to grant authority to administer and to perform all and singularly any examinations, treatments, anesthetics, operations and diagnostic procedures which may now or during the course of the patient's care be deemed advisable and necessary. This form will be used only in case of emergencies and after every reasonable effort is made to contact parents/guardians prior to admitting the patient for necessary treatment. Consent is also given for release of information for insurance purposes, and I submit authorization for responsible third party to pay directly to the treating hospital, insurance benefits due me for services rendered.

HIPPA Consent/Authorization: I hereby authorize the physicians, athletic trainers, sports medicine staff and other health-care personnel representing Jacksonville Orthopedic Institute to release information regarding my student athlete's protected health information and regarding any injury or illness during training for and participation in athletics at _____ School. This information is only to be used for the betterment of the student athlete and can only be shared with a coach, athletic director, or school official in connection with participation in interscholastic sports. This protected health information may concern the student athlete's medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable health information. This protected information may be released to other health care providers, hospital and/or medical athlete's participation in _____ School athletics.

SIGNATURES (both required):

Minor Patient _____ Parent or Guardian _____

Address (if different) _____

Family Physician _____ Emergency Tel. _____

STATE OF FLORIDA, COUNTY OF _____ before me personally appeared _____

To me well known and known to me to be the person described in and who executed this foregoing instrument, and acknowledged to and before me that executed said instrument for the purposes therein expressed.

Notary Public, State of Florida at Large Date (Seal)

ACKNOWLEDGEMENT OF WARNING BY PARENTS

We/I the parent(s) of _____ do hereby acknowledge that we/I have been fully advised, cautioned and warned by the proper administrative and coaching personnel of _____ that our/my child named above may suffer serious injury, including but not limited to sprains, fractures, brain damage, paralysis or even death, by participating in the sport of _____. Notwithstanding such warnings, and with full knowledge and understanding of the risk of serious injury to our/my child named above which may result, we/I give our/my consent to _____ to participate in the sport of _____.

Witnesses _____ Signature of Parent/Guardian _____

Date _____

A. _____ Physical exam forms must be on file with the school before tryouts/practice.

B. _____ Medical history on reverse side must be completed by parent or guardian.



CATHOLIC GRADE SCHOOL SPORTS CONFERENCE MEDICAL HISTORY SHEET

STUDENT'S NAME: _____ DOB: _____

CIRCLE YES OR NO (FURTHER DESCRIBE YES ANSWER TO THE RIGHT)

- YES NO HISTORY OF HIGH BLOOD PRESSURE _____
 - YES NO HISTORY OF HEART OR BLOOD VESSEL DISEASE _____
 - YES NO LIVER OR KIDNEY PROBLEMS _____
 - YES NO PREVIOUS STROKES – C.V.A. _____
 - YES NO DIABETES _____
 - YES NO EPILEPSY _____
 - YES NO RESPIRATORY DIFFICULTIES _____
 - YES NO BROKEN BONES _____
 - YES NO SENSORY DISTURBANCES _____
 - YES NO ARTHRITIS OR JOINT PROBLEMS _____
 - YES NO SPECIAL DIET RESTRICTIONS _____
 - YES NO PRESENTLY HAVE ANY METAL IMPLANTS _____
 - YES NO PRESENTLY HAVE A PACEMAKER _____
 - YES NO ANY PRESENT VISUAL PROBLEMS _____
 - YES NO ANY PRESENT HEARING PROBLEMS (HEARING AID) _____
 - YES NO ANY UNUSAL REACTION TO HEAT OR COLD _____
 - YES NO ANY ALLERGIES _____
 - YES NO CONCUSSIONS (LIST DATES) _____
- LIST CURRENT MEDICATIONS _____
- _____

LIST PREVIOUS MAJOR HOSPITALIZATION/SURGERIES _____

PARENT OR GUARDIAN SIGNATURE

DATE

PHYSICAL EXAM BY PHYSICAN

Height (inches) _____
Blood Pressure _____
Vision _____

Weight (pounds) _____
Pulse _____
Contacts/glasses _____

WNL ABN

WNL ABN

HEENT _____

NECK _____

LUNGS _____

HEART _____

ABDOMEN _____

GENITALS _____

SKIN _____

NECK _____

SPINE _____

SHOULDER _____

 STABILITY _____

 IMPINGEMENT _____

ELBOW _____

WRIST _____

HAND _____

HIP _____

ANKLE _____

 ALIGNMENT _____

 STABILITY _____

FEET _____

KNEE _____

MCL _____

LCL _____

ACL _____

PCL _____

MENISCUS _____

PATELLA _____

PAIN _____

APPREHENSION _____

CREPITATION _____

FUNCTIONAL TEST _____

ONE LEG HOP _____

FULL SQUATS _____

NEEDS FURTHER EVALUATION YES NO

CLEARED FOR PARTICIPATION YES NO

COMMENTS: _____

PHYSICIAN'S/NURSE PRACTITIONER'S/PHYSICIAN'S ASSISTANT'S SIGNATURE

DATE