PARENT/GUARDIAN CONSENT FORM

Parent/Guardian consent, medical history, and physical evaluation are to be completed:
1. New Students
2. Students participating in school sports programs.

Student's Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Age: _____ Grade: _____ Sex: _____

Home Street Address: _____

City: _____ State: _____ Zip Code: _____

Mom/Guardian Name: _____

Home #: _____ Cell #: _____ Pager # _____

Work Place_____ Work #: _____

Father/Guardian Name: _____

Home #: _____ Cell #: _____ Pager # _____

Work Place_____ Work #: _____

Name of Insurance Provider: _____ Policy Number: _____

Name of Insured: _____Social Security Number: _____

Physician's Name: _____ Phone: _____

Dentist's Name: _____ Phone: _____

HEALTH HISTORY: (Please explain any yes answers)

a) Any known chronic illness; Asthma, Cystic Fibrosis, Diabetes, Heart, etc. Yes: _____ No: _____

_____

b) Any known allergies; drug, environmental, food; describe: Yes: _____ No: _____

_____

c) History of head injury, concussion, seizure, etc.? Yes: _____ No: _____

_____

d) History of hospitalization or surgery; explain: Yes: _____ No: _____

_____

e) Any spinal injuries or spinal defects: Yes: _____ No: _____

_____

f) List **all** medications taken on a daily basis: Yes: _____ No: _____

_____

g) Note special concerns regarding participation in physical education, athletics or sports for your child:

_____

h) Does your child wear contact lens (eyes) or have any orthodontic appliance in their mouth? Yes: ___ No:___

_____

i) Any recurrent skin rashes, abscesses in past year? (Explain) Yes: _____ No: _____

_____

MEDICAL INFORMATION

Date of Student's Last Tetanus Booster Vaccination: _____

Drug Allergies or Other Medical Conditions: _____

In case of Emergency, when the above people can not be located call:

_____ Home #: _____ Work #: _____ Cell/Pager #: _____

_____ Home #: _____ Work #: _____ Cell/Pager #: _____

Consent

I, _____, grant permission for my child _____ to participate in extracurricular athletic activities. These activities will take place under the guidance and direction of school employees and/or volunteers. As a parent and/or legal guardian, I remain legally responsible for personal actions taken by the above named minor ("student"). I agree on behalf of myself, my child named herein, our heirs, successors and assigns, to hold harmless and defend _____, its employees, officers, directors and agents, and the Archdiocese of Galveston-Houston, or representatives associated with these activities, arising from or in connection with my child participating in these activities, or in connection with any illness, injury or cost of medical treatment in connection therewith, and I agree to compensate _____, its officers, directors and agents, and the Archdiocese of Galveston-Houston, or representatives associated with the activity for reasonable attorney's fees and expenses arising in connection therewith.

I hereby warrant to the best of my knowledge, that my child is in good health, and I assume all responsibility for the health and medical care of my child. In the event of a medical emergency, I hereby give permission to school employees and/or volunteers supervising the athletic event to obtain medical services and to transport my child to the nearest hospital/emergency care center for emergency medical or surgical treatment.

_____ _____ _____

Parent/Guardian Signature Relationship Date

PHYSICAL EXAMINATION FORM

Student's Name: _____ Height: _____ Weight: _____ Pulse: _____ Blood Pressure: _____

Vision R 20/_____ L 20/_____ Corrected: Yes____ No____ Pupils: Equal ____ Unequal ____

Hearing: Normal _____ Referred _____ Spinal Exam: Normal _____ Referred _____ % Body Fat (optional)_____

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in the supine			
Heart-Auscultation of the heart in the standing position			
Heart-Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			

MUSCULOSKELETAL

Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

CLEARANCE

☐ Cleared for Participation

☐ Not cleared for Participation Reason: _____

Recommendations and/or Restrictions: _____

_____

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 Practiced Nurse by the Board of Nurse Examiners.

Name (print/type): _____ Date of Examination: _____

Address: _____ Phone Number: _____

Signature: _____ Title: _____