

**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: \_\_\_\_\_