THIS FORM IS TO BE COMPLETED FOR ALL OLPH STUDENT ATHLETES

OUR LADY OF PERPETUAL HELP CATHOLIC SCHOOL ATHLETIC PARTICIPATION PARENTAL CONSENT FORM (this form must be signed in two places)

EMERGENCY TREATMENT:

To all Parents/Guardians: Since the malpractice question has come to the forefront, many hospitals and doctors will not treat a minor without the parent's consent (unless it is a life-threatening situation). It is requested that you complete the information below so that in case it is necessary for your child to be treated in a hospital or by a physician while under the supervision of the school, this consent will facilitate that treatment.

MEDICAL CONSENT:

I/We hereby grant permission to Our Lady of Perpetual Help School, its physicians and/or Athletic Trainers to render first aid, treatment, medical or surgical care deemed reasonable and/or necessary for the health and well being of the student named below.
I/We further authorize the Athletic Trainers at the above-named institution who are under the direction and guidance of a physician to render any preventive, rehabilitative or emergency treatment deemed reasonable and/or necessary to protect the health and well being of the student named below.
I/We additionally grant, when necessary for protecting the health and well being of the student named below, permission for hospitalization, treatment or surgery at a competent and/or accredited facility.
I/We further release Our Lady of Perpetual Help School, the physicians, Athletic Trainers, agent's servants, and employees from any liability for damage and injury to the student named below and hereby accepts the full responsibility for any and all damages or injuries sustained as a result of participation in the sports indicated below.

Student Name: _____ DOB _____

Address _____ Phone _____

Mother _____ Father _____

Work Address _____ Work Address _____

Work Phone _____ Cell _____ Work Phone _____ Cell _____

Secondary Contact: _____ Relationship _____ Phone _____

Insurance Co: _____ Policy# _____ Group# _____

Allergies _____ Medical Conditions _____

Consent for Authorization of Medical Treatment:

****Signature of Parent** _____ **Date** _____

Parental Consent to Participate in Athletics:

I hereby state that all of the information above is correct, to the best of my knowledge, and I further give consent

for (student's name) _____ to represent(school) _____

In the following sports: _____

****Signature of Parent** _____ **Date** _____

TSSAA Athletics Participation Medical Evaluation Form

Personal History to be completed by parent and/or student:

Name:_____ DOB_____ Age_____ Male Female

Address _____ Phone _____ Cell _____

School _____ Grade_____ Sports _____

Personal Physician _____ Address _____ Phone _____

Have you ever had a Pre-participation physical before? _____ yes _____ no When/Where_____

Circle YES or NO; if yes please explain is space provided:

Yes	No	Have you ever been hospitalized?
Yes	No	Have you ever had surgery?
Yes	No	Are you presently taking any medications?
Yes	No	Do you have any serious Allergies (medicine, food, bees, ETC.)?
Yes	No	Have you ever fainted, been dizzy, had chest pain or rapid heartbeat, or tired easily during exercise?
Yes	No	Have you ever had high blood pressure or a heart murmur?
Yes	No	Has anyone in your family died of heart problems or a sudden death prior to age 50?
Yes	No	Do you have any skin problems (itching, rashes, severe acne)?
Yes	No	Have you ever had a head injury, been knocked unconscious, or had a seizure?
Yes	No	Have you ever had a stinger, burner, or pinched nerve?
Yes	No	Have you ever passed out form the heat or had heat or muscle cramps?
Yes	No	Do you have trouble breathing or do you cough during or after exercise?
Yes	No	Do you use any special protective equipment?
Yes	No	Have you had any problems with you eyes or vision?
Yes	No	Do you wear glasses, contacts, or Protective eyewear?
Yes	No	Have you had any other serious medical problems?
Yes	No	Have you had any medical or surgical problems since your last evaluation?

Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling of any bones or joints?
Circle all that apply:

Head	**shoulder**	**thigh**	**Neck**	**Elbow**
Knee	**chest**	**forearm**	**shin/calf**	**foot**
Back	**wrist**	**ankle**	**hip**	**hand**

Date of last Tetanus shot _____ Date of last measles shot _____
Date of onset of menses? _____ Date of Last Menstrual Period? _____ duration _____

Explain "YES" answers here:

This portion to be completed by Physician, Nurse Practitioner, or Physician Assistant:

GENERAL PHYSICAL EXAMINATION

Height _____ Weight _____ B/P _____ Pulse _____ Vision R20/____ L20/_____ corrected?_____ Pupils _____

	NORMAL	ABNORMAL FINDINGS
Ears, Nose Throat	_____	_____
Heart	_____	_____
Chest/Lungs	_____	_____
Skin/Lymphatics	_____	_____
Abdominals	_____	_____
Genitalia/Hernia	_____	_____

MUSCULOSKELETAL EXAMINATION

Neck/back	_____	_____
Upper extremities	_____	_____
Lower extremities	_____	_____
Flexibility	_____	_____

Official Recommendation: This athlete may _____ May NOT _____ compete in athletics based on this exam.
Further treatment or follow-up is recommended _____

Signature of Examiner _____ **Date** _____