

The following forms (3) must be completed in full and submitted to the School Office or Athletic Department in order for an athlete to try out for any sport. Once submitted, the athlete is eligible to try out for any sport during that school year.

Physical Examinations must be performed on or after June 1st in order to be valid for the following school year.

Elementary Schools in the Diocese of St. Petersburg

Nativity Catholic School -- Brandon, Florida

ATHLETIC PARTICIPTION FORM

Date _____

Student Name: _____ Grade _____ DOB: _____
 (Name as it Appears on Birth Certificate)

Residence _____ City _____ Zip _____

EMERGENCY MEDICAL TREATMENT PERMISSION AND INFORMATION

I hereby authorize the school to obtain, through a physician of its own choice, any emergency care that may become reasonably necessary for the student in the course of daily school activities, athletic activities or travel. Payment of all charges incurred for medical treatment is guaranteed by me or the insurance company providing coverage for the above named student.

- 1) Allergies and/or special medical problems (list medications taken by student)
- 2) Date of last Tetanus shot
- 3) Family Physician _____ Phone _____

INSURANCE: (School) _____ provides insurance coverage for all students while participating in interscholastic athletic teams sponsored by the school. The cost of this coverage is included in the student activity fee.
(Insurance Company) _____ acts as a secondary co-insurer and will only pay after they receive proof that your insurance company has settled with you.

*In the case of an injury, the student/athlete is to report that injury, no matter how slight, to his/her teacher/coach immediately. The teacher/coach will then notify the main office through the use of the proper form. If a claim form is needed, the student/athlete or his/her parents are to request a claim form from the main office or the Athletic Office. The claim form is to be completed by the parents and mailed directly to _____ Insurance Company for processing.

STUDENT PARTICIPATION PERMISSION

Participation in competitive athletics may result in severe injury, including paralysis, or death. Improvement in equipment, medical treatment and physical conditioning, as well as rule changes, have reduced these risks, but it is impossible to totally eliminate such occurrences from athletics.

I hereby give my consent for the above named student to represent his/her school in athletic activities, including team travel for local or out-of-town trips, except for those activities crossed out below:

- | | | | | |
|------------|------------|----------|-----------------|----------|
| Baseball | Basketball | Track | Cheerleading | Football |
| Golf | Soccer | Softball | Swimming/Diving | Tennis |
| Volleyball | | | | |

(School) _____ follows

The Diocese of St. Petersburg Guidelines for Elementary Interscholastic Athletics, and any policies or procedures as outlined in the school's handbook

STATEMENT:

I have read this form and understand the rules contained herein. The information supplied is true and correct to the best of my knowledge. I accept the responsibility to inform the school of any change of this information.

Student Signature _____

Parent/Guardian Signature _____

Home Phone _____ Work Phone _____ Cell Phone _____

Other Emergency Contact (Name) _____

Phone _____

NOTARIZATION OF PARENT SIGNATURE

STATE OF FLORIDA

COUNTY OF _____

The foregoing instrument was acknowledged before me this _____ day of _____, _____ year by _____, who is personally known to me or who has produced as identification.

NOTARY SIGNATURE

Printed Name of Notary: _____

My Commission Expires: _____

Serial Number: _____

raised seal

Elementary Schools in the Diocese of St. Petersburg
 Pre-participation Physical Evaluation P. 1 of 2
Nativity Catholic School -- Brandon, Florida

DATE _____

**Form must be completed in its entirety. No other documentation should be attached.
 Completed form must be filed in the school office.**

Part 1. Student Information (to be completed by parent)

Student's Name: _____ Gender: _____ Age: _____ Date of Birth: _____
 School: _____ Grade: _____ Sport(s): _____
 Home Address: _____ Home Phone: _____
 City/ State/Zip code _____ Work Phone: _____
 Name of Parent/Guardian: _____ Other _____
 Person to Contact in Case of Emergency: _____ Phone _____ Other _____ Relationship to student: _____
 Personal / Family Physician _____ Office Phone: _____

Part 2. Medical History (to be completed by parent). Explain "yes" answers below.(Circle questions you don't know answers to.)

	Yes	No		Yes
1. Has the student had a medical illness or injury since the last check up or sports physical?			26. Has the student ever become ill from exercising in the heat?	
2. Does the student have an ongoing chronic illness?			27. Does the student cough, wheeze, or have trouble breathing during or after activity?	
3. Has the student ever been hospitalized overnight?			28. Does the student have asthma?	
4. Has the student ever had surgery?			29. Has the student have seasonal allergies that require medical treatment?	
5. Is the student currently taking any prescription or nonprescription (over the counter) medications or pills or using an inhaler?			30. Does the student use any special protective or corrective equipment or devices that aren't usually used for sports (for example, knee brace, special neck roll, tooth retainer, hearing aid)?	
6. Has the student ever taken any supplements or vitamins to aid in gaining or losing weight or improving performance?			31. Has the student had any problems with his/her eyes or vision?	
7. Does the student have any allergies (ie, pollen, medicine, food, or insect stings)?			32. Does the student wear glasses, contacts, or protective eyewear?	
8. Has the student ever had a rash or hives develop during or after exercise?			33. Has the student ever had a sprain, strain, or swelling after injury?	
9. Has the student ever passed out during or after exercise?			34. Has the student broken or fractured any bones or dislocated any joints?	
10. Has the student ever been dizzy during or after exercise?			35. Has the student had any other problems with pain or swelling in muscles, tendons, bones, or joints?	
11. Has the student ever had chest pain during or after exercise?			If yes, check appropriate blank and explain below	
12. Does the student get tired more quickly than others during exercise?			shoulder _____ finger _____ head _____	
13. Has the student ever had a racing heart/ skipped heartbeats?			upper arm _____ foot _____ neck _____	
14. Has the student had high blood pressure/ high cholesterol?			elbow _____ thigh _____ back _____	
15. Has the student ever been told he/she has a heart murmur?			forearm _____ knee _____ chest _____	
16. Has any family member or relative died of heart problems or sudden death before age 50?			wrist _____ shin/calf _____ hip _____	
17. Has the student had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?			hand _____ ankle _____	
18. Has a physician ever denied or restricted participation in sports for any heart problems?			36. Date of most recent tetanus shot: _____	
19. Does the student have any current skin problems (e.g., itching, rashes, acne, warts, fungus, or blisters)?			Explain any "yes" responses here:	
20. Has the student ever had a head injury or concussion?			# _____	
21. Has the student ever been knocked out, become unconscious, or lost his/her memory?			_____	
22. Has the student ever had a seizure?			# _____	
23. Does the student have frequent or severe headaches?			_____	
24. Has the student ever had numbness or tingling in arms, hands, legs, or feet?			# _____	
25. Has the student ever had a stinger, burner, or pinched nerve?			_____	

Additional Notations:

We hereby state, to the best of our knowledge, that our answers to the above questions are complete and correct. In addition to the routine medical evaluations required by the State of Florida and the Elementary Schools in the Diocese of St. Petersburg, we understand and acknowledge that it is suggested that the student should undergo formal assessments of the heart, which may include such diagnostic tests as catheterization, electrocardiogram (EKG), echocardiogram (ECG) and/or cardio stress test.

Signature of Parent/Guardian _____
 Date _____

For School Office: Date received: _____ Administrator signature _____

NAME OF SCHOOL _____

Part 3. Physical Examination (to be completed by physician)

Student's Name _____ Date of Birth _____
 Height: _____ Weight: _____ Pulse: _____ Blood Pressure: _____
 Visual Acuity: Right 20/____ Left 20/____ Corrected: Pupils: Equal ____ Unequal ____

Findings	Normal	Abnormal Findings	Initials
Medical			
1. Appearance			
2. Eyes/Ears/Nose/Throat			
3. Lymph Nodes			
4. Heart			
5. Pulses			
6. Lungs			
7. Abdomen			
8. Genitalia (males only)			
9. Menstrual Cycle			
10. Skin			
11. Musculoskeletal			
12. Neck			
13. Back			
14. Shoulder/Arm			
15. Elbow/Forearm			
16. Wrist/Hand			
17. Hip/Thigh			
18. Knee			
19. Leg/Ankle			
20. Foot			

* - Station-based examination only

ASSESSMENT OF EXAMINING PHYSICIAN

I hereby certify that each examination listed above was performed by myself or an individual under my direct supervision with the following conclusions:

Cleared without limitation _____
 Not cleared for: _____ Reason: _____
 Cleared after completing evaluation/rehabilitation for: _____
 Referred to: _____ For: _____
 Recommendations: _____

Name of Physician (print or type) _____ Date: _____
 Address: _____

Signature of Physician: _____, **MD or DO**

ASSESSMENT OF PHYSICIAN TO WHOM REFERRED (if applicable)

I hereby certify that the examination(s) for which referred was/were performed by myself or an individual under my direct supervision with the following conclusion(s)

Cleared without limitation _____
 Not cleared for: _____ Reason: _____
 Cleared after completing evaluation/rehabilitation for: _____
 Recommendations: _____

Name of Physician (print or type) _____ Date: _____
 Address: _____

Signature of Physician: _____, **MD or DO**