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 medica 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 indentification.

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?	
			32. Does the student wear glasses, contacts, or protective eyewear?	
			33Has the student ever had a sprain, strain, or swelling after injury?	
7.Does the student have any allergies (ie, pollen, medicine, food, or insect stings)?			34. Has the student broken or fractured any bones or dislocated any joints?	
8.Has the student ever had a rash or hives develop during or after exercise?			35. Has the student had any other problems with pain or swelling in muscles, tendons, bones, or joints?	
9.Has the student ever passed out during or after exercise?			If yes, check appropriate blank and explain below	
10.Has the student ever been dizzy during or after exercise?			shoulder _____ finger _____ head _____	
11.Has the student ever had chest pain during or after exercise?			upper arm _____ foot _____ neck _____	
12.Does the student get tired more quickly than others during exercise?			elbow _____ thigh _____ back _____	
			forearm _____ knee _____ chest _____	
13.Has the student ever had a racing heart/ skipped heartbeats?			wrist _____ shin/calf _____ hip _____	
14. Has the student had high blood pressure/ high cholesterol?			hand _____ ankle _____	
15. Has the student ever been told he/she has a heart murmur?			36. Date of most recent tetanus shot:	
16. Has any family member or relative died of heart problems or sudden death before age 50?			**Explain any "yes" responses here:**	
17. Has the student had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?			#___ _____	
18. Has a physician ever denied or restricted participation in sports for any heart problems?			_____	
19. Does the student have any current skin problems (e.g., itching, rashes, acne, warts, fungus, or blisters)?			#___ _____	
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 catherization, 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 indiviual 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

NB: This form was based on recommendations developed by the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society, for Sports Medicine. American Orthopaedic Society for Sports Medicine and American Osteopathic Academy for Sports Medicine and the FHSAA