CATHOLIC GRADE SCHOOL SPORTS CONFERENCE
STUDENT ATHLETIC PARTICIPATION APPLICATION

This form is effective from the date indicated on the form, until the end of the current school year. This form must be on file in the School office prior to any student participating in either tryouts or appropriate athletic practice or competition.

_____ _____ _____ _____
Student's Last Name First Middle Initial Application Date

This application to compete in interscholastic athletics for _____School is entirely voluntary on my part, and is made with the understanding that I have not violated any of the eligibility rules and regulations. _____
Signature of Student

Parent or Guardian's permission: I hereby give my consent for the above student to engage in school approved athletic activities as a representative of his/her school. I agree to allow the above named student to be a passenger in a privately operated vehicle to and from athletic events. I hereby release and discharge the Diocese of St. Augustine, Bishop Victor Galeone, _____ School, its agents and employees from liability growing out of personal injuries and property damage resulting or occurring during transport to and from said activity.

Date _____ Signature of Parent or Guardian _____

Street Address _____ City _____ Zip _____ Tel. #_____

MEDICAL RELEASE: SIGN THIS SECTION <u>ONLY IN THE PRESENCE</u> OF YOUR NOTARY PUBLIC.

The patient and others, whose signatures appear below, do hereby consent to any and all medical, dental and surgical treatments including anesthesia and operations, which may be deemed advisable by his/her physicians and surgeons as a result of his/her participation in athletic activities. The intention hereof being to grant authority to administer and to perform all and singularly any examinations, treatments, anesthetics, operations and diagnostic procedures which may now or during the course of the patient's care be deemed advisable and necessary. This form will be used only in case of emergencies and after every reasonable effort is made to contact parents/guardians prior to admitting the patient for necessary treatment. Consent is also given for release of information for insurance purposes, and I submit authorization for responsible third party to pay directly to the treating hospital, insurance benefits due me for services rendered.

HIPPA Consent/Authorization: I hereby authorize the physicians, athletic trainers, sports medicine staff and other health-care personnel representing Jacksonville Orthopedic Institute to release information regarding my student athlete's protected health information and regarding any injury or illness during training for and participation in athletics at _____School. This information is only to be used for the betterment of the student athlete and can only be shared with a coach, athletic director, or school official in connection with participation in interscholastic sports. This protected health information may concern the student athlete's medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable health information. This protected information may be released to other health care providers, hospital and/or medical athlete's participation in _____ School athletics.

SIGNATURES (both required):

Minor Patient _____ Parent or Guardian _____

Address (if different)_____

Family Physician_____ Emergency Tel. _____

STATE OF FLORIDA, COUNTY OF _____ before me personally appeared _____
To me well known and known to me to be the person described in and who executed this foregoing instrument, and acknowledged to and before me that executed said instrument for the purposes therein expressed.

_____ _____
Notary Public, State of Florida at Large Date (Seal)

ACKNOWLEDGEMENT OF WARNING BY PARENTS

We/I the parent(s) of _____ do hereby acknowledge that we/I have been fully advised, cautioned and warned by the proper administrative and coaching personnel of _____ that our/my child named above may suffer serious injury, including but not limited to sprains, fractures, brain damage, paralysis or even death, by participating in the sport of _____. Notwithstanding such warnings, and with full knowledge and understanding of the risk of serious injury to our/my child named above which may result, we/I give our/my consent to _____ to participate in the sport of _____.

Witnesses _____ Signature of Parent/Guardian_____

_____ Date _____

A._____ Physical exam forms must be on file with the school before tryouts/practice.

B._____ Medical history on reverse side must be completed by parent or guardian.

CATHOLIC GRADE SCHOOL SPORTS CONFERENCE
MEDICAL HISTORY SHEET

STUDENT'S NAME: _____ Date:_____

CIRCLE YES OR NO **(FURTHER DESCRIBE YES ANSWER TO THE RIGHT)**

YES NO HISTORY OF HIGH BLOOD PRESSURE _____
YES NO HISTORY OF HEART OR BLOOD VESSEL DISEASE _____
YES NO LIVER OR KIDNEY PROBLEMS _____
YES NO PREVIOUS STROKES – C.V.A. _____
YES NO DIABETES _____
YES NO EPILEPSY _____
YES NO RESPIRATORY DIFFICULTIES _____
YES NO BROKEN BONES _____
YES NO SENSORY DISTURBANCES _____
YES NO ARTHRITIS OR JOINT PROBLEMS _____
YES NO SPECIAL DIET RESTRICTIONS _____
YES NO PRESENTLY HAVE ANY METAL IMPLANTS _____
YES NO PRESENTLY HAVE A PACEMAKER _____
YES NO ANY PRESENT VISUAL PROBLEMS _____
YES NO ANY PRESENT HEARING PROBLEMS (HEARING AID) _____
YES NO ANY UNUSAL REACTION TO HEAT OR COLD _____
YES NO ANY ALLERGIES _____
YES NO CONCUSSIONS (LIST DATES) _____

LIST CURRENT MEDICATIONS _____
_____
_____

LIST PREVIOUS MAJOR HOSPITALIZATION/SURGERIES _____
_____
_____

_____ _____
PARENT OR GUARDIAN SIGNATURE DATE

PHYSICAL EXAM BY PHYSICAN

Height (inches) _____
Blood Pressure _____
Vision _____

Weight (pounds) _____
Pulse _____
Contacts/glasses _____

	WNL	ABN
HEENT		
NECK		
LUNGS		
HEART		
ABDOMEN		
GENITALS		
SKIN		
NECK		
SPINE		
SHOULDER		
STABILITY		
IMPINGEMENT		
ELBOW		
WRIST		
HAND		
HIP		

	WNL	ABN
ANKLE		
ALIGNMENT		
STABILITY		
FEET		
KNEE		
MCL		
LCL		
ACL		
PCL		
MENISCUS		
PATELLA		
PAIN		
APPREHENSION		
CREPITATION		
FUNCTIONAL TEST		
ONE LEG HOP		
FULL SQUATS		

NEEDS FURTHER EVALUTION YES NO
CLEARED FOR PARTICIPATION YES NO
COMMENTS:

_____
_____ _____
PHYSICIAN'S SIGNATURE DATE