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. Middle Initial Application Date Student's Last Name This application to compete in interscholastic athletics for ______School is entirely voluntary on my part, and is made with the Signature of Student understanding that I have not violated any of the eligibility rules and regulations. 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 Felipe Estavez, _______ 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 _____ _____ City _____ Zip ____ Tel. #____ Street Address MEDICAL RELEASE: SIGN THIS SECTION ONLY IN THE PRESENCE 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 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/l give our/my consent to to participate in the sport of Signature of Parent/Guardian

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 N	0	(F	URTHER DESC	CRIBE YES ANSWER TO T	HE RIGHT)		
YES NO	HISTORY OF HIGH BI	OOD PRESSURE			•		
YES NO	HISTORY OF HEART OR BLOOD VESSEL DISEASE						
YES NO	LIVER OR KIDNEY PROBLEMS						
YES NO	PREVIOUS STRUKES	– C.V.A					
YES NO	DIABETES						
YES NO	EPILEPSY						
YES NO	RESPIRATORY DIFFIC	CULTIES					
YES NO YES NO	RENCODA DISTRIBUM	NCEC					
YES NO	SENSORY DISTURBANCESARTHRITIS OR JOINT PROBLEMS						
YES NO	SPECIAL DIET RESTRICTIONS						
YES NO	SPECIAL DIET RESTRICTIONS 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 ALLERGIESCONCUSSIONS (LIST DATES)						
YES NO	CONCUSSIONS (LIST	DATES)					
LIST CURRENT ME	EDICATIONS						
LIST PREVIOUS M	A IOR HOSPITALIZATIO	N/SI IDGEDIES					
LIST FIXEVIOUS IVI	AJON HOSFITALIZATIO	MOUNGLNILS					
PARENT OR GUARDIAN SIGNATURE					DATE		
		PHYSI	ICAL EXAM	BY PHYSICAN			
Height (inches)							
Blood Pressure							
Vision				Contacts/glasses			
	WNL	ABN			WNL	ABN	
HEENT				ANKLE			
NEOK				AINCL			
LUNGS				STABILITY			
LIEADT			· · · · · · · · · · · · · · · · · · ·	FEET		·	
				KNEE			
GENITALS				MCL			
SKIN				LCL			_
NECK				ACL			_
SPINE				PCL			_
SHOULDER				MENISCUS			_
STABILITY_	UT.			PATELLA			
IMPINGEMEN	NT			PAIN			-
M/DIST				APPREHENSION			-
MKIST				CREPITATION FUNCTIONAL TEST			-
HIP				ONE LEG HOP			_
				FULL SQUATS			_
NEEDS FURTHER	EVALUTION	YES	NO	TOLL OQUATO			-
CLEARED FOR PA		YES	NO				
COMMENTS:		0					
					<u> </u>		
PHYSICIAN'S SIGN	IATURE		DATE				