

OUR LADY'S CHRISTIAN SCHOOL ATHLETICS

This form is to be completed by the parent/guardian and by the Medical Examiner.
The form must be returned to Our Lady's Christian School **prior** to any student participating in Practices, Inter-School Practices, Scrimmages, and/or Contests.

Pre-Participation Personal and Emergency Information

PERSONAL INFORMATION

Student's Name: _____ Male/Female (circle one)

Date of Student's Birth: ____ / ____ / ____ Age of Student on Last Birthday: ____ Grade for Current School Year: ____

Current Physical Address: _____

Current Home Phone # () _____ Parent/Guardian Current Cellular Phone # () _____

Fall Sport(s): _____ Winter Sport(s): _____ Spring Sport(s): _____

EMERGENCY INFORMATION

Parent's/Guardian's Name: _____ Relationship: _____

Address: _____ Emergency Contact Telephone # () _____

Secondary Emergency Contact Person's Name: _____ Relationship: _____

Address: _____ Emergency Contact Telephone # () _____

Medical Insurance Carrier: _____ Policy Number: _____

Address: _____ Telephone # () _____

Family Physician's Name: _____, MD or DO (circle one)

Address: _____ Telephone # () _____

Student's Allergies: _____

Student's Health Condition(s) of Which an Emergency Physician Should be Aware: _____

Student's Prescription Medications: _____

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CERTIFICATION TO RETURN TO SPORT(S) BY LICENSED PHYSICIAN OF MEDICINE OR OSTEOPATHIC MEDICINE

This form must be completed for any student who required medical treatment from a licensed physician of medicine or osteopathic medicine. This form may be completed at any time following completion of such medical treatment. Upon completion, the Form must be turned into the Principal of Our Lady's Christian School.

If the physician completing this form is clearing the named student subsequent to that student sustaining a concussion or head injury, that physician must be sufficiently familiar with current concussion management such that the physician can certify that all aspects of evaluation, treatment, and risk of that injury have been thoroughly covered by that physician.

Student Name: _____ Age: _____ Grade: _____

Condition(s) Treated Since Completion of the Herein Named Student's Pre-Participation Certification Form: _____

A. GENERAL CLEARANCE: Absent any illness and/or injury, which requires medical treatment, subsequent to the date set forth below, I hereby authorize the above identified student to participate for the remainder of the current school year in additional interscholastic athletics with no restrictions, except those, if any set forth in the student's Pre-Participation Form.

Physician's Name (print/type): _____ License # _____

Address: _____ Phone # () _____

Physician's Signature: _____ MD or DO (circle one) Date: _____

B. LIMITED CLEARANCE: Absent any illness and/or injury, which requires medical treatment, subsequent to the date set forth below, I hereby authorize the above identified student to participate for the remainder of the current school year in additional interscholastic athletics with, in addition to the restrictions, if any set forth in the student's Pre-Participation Form, the following limitations/restrictions:

1. _____

2. _____

3. _____

Physician's Name (print/type): _____ License # _____

Address: _____ Phone # () _____

Physician's Signature: _____ MD or DO (circle one) Date: _____

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CERTIFICATION TO RETURN TO SPORT(S) BY PARENT/GUARDIAN

This form must be completed not earlier than six weeks prior to the first Practice day of the sport(s) in the sports season(s) identified herein by the parent/guardian of any student who is seeking to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in all subsequent sport seasons in the same school year. The Principal of Our Lady's Christian School must review the **SUPPLEMENTAL HEALTH HISTORY**.

SUPPLEMENTAL HEALTH HISTORY

Student's Name: _____ Male/Female (circle one)

Age: _____ Birthdate: ____/____/____ Grade: _____

Winter Sport(s): _____ Spring Sport(s): _____

CHANGES TO PERSONAL INFORMATION (In the space below, identify any changes to the Personal Information set forth in the original **PRE-PARTICIPATION PERSONAL AND EMERGENCY INFORMATION**.)

Current Home Address: _____

Current Home Telephone # () _____ Parent/Guardian Current Cell Phone # () _____

CHANGES TO EMERGENCY INFORMATION (In the spaces below, identify any changes to the Emergency Information set forth in the original **EMERGENCY INFORMATION**.)

Parent's/Guardian's Name: _____ Relationship: _____

Address: _____ Emergency Contact Telephone # () _____

Secondary Emergency Contact Person's Name: _____ Relationship: _____

Address: _____ Emergency Contact Telephone # () _____

Medical Insurance Carrier: _____ Policy Number: _____

Address: _____ Telephone # () _____

SUPPLEMENTAL HEALTH HISTORY:

Explain "Yes" answers at the bottom of this form. Circle questions you don't know the answers to.

1. Since completion of Pre-Participation Personal and Emergency Information has student sustained an illness and/or injury that required medical treatment from a licensed physician of medicine or osteopathic medicine?

Yes _____ No _____

2. Since completion of Pre-Participation Personal and Emergency Information has student had a concussion?

Yes _____ No _____

3. Since completion of Pre-Participation Personal and Emergency Information has student had dizzy spells, blackouts and/or unconsciousness? Yes _____ No _____

4. Since completion of Pre-Participation Personal and Emergency Information has student experienced any episodes of unexplained shortness of breath, wheezing, and/or chest pain? Yes _____ No _____

5. Since completion of Pre-Participation Personal and Emergency Information is student taking any new prescription or non-prescription medicines or pills? Yes _____ No _____

#1: _____

#2: _____

#3: _____

#4: _____

#5: _____

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Parent's/Guardian's Signature: _____ Date: ____/____/____

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CERTIFICATION OF MEDICAL EXAMINER

Must be completed and signed by the Authorized Medical Examiner performing the physical examination for the student named below.

Student's Name: _____ Age: _____ Grade: _____

Sport(s): _____ Height: _____ Weight: _____

BP ____/____ (____/____, ____/____) RP _____ If either the blood pressure (BP) or resting pulse (RP) is above the following levels, further evaluation by the student's primary care physician is recommended.

Age 10-12: BP>126/82 RP: 104 Age 13-15: BP>136/86 RP: 100

Vision: R 20/_____ L 20/_____ Corrected: YES / NO (circle one) Pupils: Equal _____ Unequal _____

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/Ears/Nose/Throat		
Hearing		
Lymph Nodes		
Cardiovascular		
Cardiopulmonary		
Lungs		
Abdomen		
Genitourinary (males only)		
Neurological		
Skin		
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		

I hereby certify that I have reviewed the HEALTH HISTORY, performed a comprehensive initial pre-participation physical evaluation of the herein named student, and, on the basis of such evaluation and the student's HEALTH HISTORY, certify that, except as specified below, the student is physically fit to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in the sport(s) consented to by the student's parent/guardian.

CLEARED **CLEARED**, with recommendation(s) for further evaluation or treatment for: _____

NOT CLEARED for the following types of sports (please check those that apply):

COLLISION CONTACT NON-CONTACT STRENUOUS MODERATELY STRENUOUS NON-STRENUOUS

Due to: _____

Recommendation(s)/Referral(s): _____

AME's Name (print/type): _____ License # _____

Address: _____ Phone # () _____

AME's Signature: _____ MD, DO, PAC, CRNP, or SNP (circle one)