## SPORTS PHYSICALS MUST BE DATED AFTER JUNE 1, 2022
## CATHOLIC GRADE SCHOOL SPORTS CONFERENCESTUDENT 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 **St. Pau l's Catholic School is** 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 Felipe Estevez, and **St. Pau l's Catholic 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 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, operation s 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 ca se 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 **St. Pau l's Catholic 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 St. Paul's Catholic 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 **St. Pau l's Catholic School** 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 all sports**. 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 **all sports**.

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 2022-23**

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 ______________