



Our Lady of Mount Carmel School

In pursuit of Truth, Goodness, & Beauty

Athletic Participation / Parental Consent / Health History Form

For School Year - Male Female

Name (Last) (First) (Middle Initial) Class Age

Home Address

City / Zip Code

Home Phone Date of Birth

ACKNOWLEDGEMENT OF RISK AND INSURANCE STATEMENT

I give permission for (name of child) to participate in the Middle School Sports Program. I am aware that participating in sports will involve travel with the team. If I am not available to drive, I give permission for my child to ride in a private vehicle driven by a Virtus trained parent volunteer, who meets diocesan guidelines for transporting students off campus. Yes No

I am aware that with the participation in sports comes the risk of injury to my child. I understand that the seriousness of the risk varies significantly from one sport to another. My child is insured by our Family Policy: Yes No

Name of Company Policy Number Name of Policy Holder

I acknowledge and accept the risks inherent in the sport and with this knowledge in mind, grant permission for my child to participate in the sport.

EMERGENCY PERMISSION FORM

Emergency Authorization: In the event I cannot be reached in an emergency, I hereby give permission to physicians selected by the coaches and staff of Our Lady of Mount Carmel School to hospitalize, secure proper treatment for and to order injection and/or anesthesia and /or surgery for the student named above.

Daytime(after school) phone number(s) where you can be reached in an emergency

Evening phone number(s) where you can be reached in an emergency

Signature of parent or guardian Date

Relationship to student

This Emergency and Health History Permission Form will be reproduced and travel with respective teams and is acceptable for emergency treatment if necessary.

This form MUST be completed by a parent or guardian, prior to starting practice for a Middle School Sports Team each year. A physical exam by your physician is recommended, but not required.

I certify all the above information is correct. Signature of parent or guardian Date

BOTH SIDES OF THIS FORM MUST BE COMPLETED

MEDICAL HEALTH HISTORY

NAME of Student _____

- | YES | NO | |
|-----|-----|---|
| ___ | ___ | 1. Have you ever had any of the following? Please explain any YES answers. |
| ___ | ___ | Heart Murmur _____ |
| ___ | ___ | High Blood Pressure _____ |
| ___ | ___ | Other Heart Problems _____ |
| ___ | ___ | Broken Bones _____ |
| ___ | ___ | Weak Joints - Ankles, Knees _____ |
| ___ | ___ | Concussion _____ |
| ___ | ___ | Operations - _____ |
| ___ | ___ | Seizures or Epilepsy _____ |
| ___ | ___ | 2. Have you ever Fainted or Passed Out? _____ |
| ___ | ___ | 3. Have you ever been Knocked Out? _____ |
| ___ | ___ | 4. Have you ever been Hospitalized? _____ |
| ___ | ___ | _____ |
| ___ | ___ | 5. Have you ever had to Stop Running after ¼ to ½ mile due to Chest Pain or Shortness of Breath? _____ |
| ___ | ___ | 6. A. Have you ever had significant allergies to: |
| ___ | ___ | Bee stings? - on medication? Yes ___ No ___ |
| ___ | ___ | Foods _____ |
| ___ | ___ | Medicine _____ |
| ___ | ___ | Others _____ |
| ___ | ___ | B. Do you have a prescription for the use of: |
| ___ | ___ | Adrenaline - EPI-PEN _____ |
| ___ | ___ | Inhalers _____ |
| ___ | ___ | Other Allergy Medicine _____ |
| ___ | ___ | C. Do you have Asthma? _____ |
| ___ | ___ | 7. Do you take any Medicine regularly? _____ |
| ___ | ___ | 8. Have you had any Blood Disorders, including Sickle Cell Trait, Anemia etc.? _____ |
| ___ | ___ | _____ |
| ___ | ___ | 9. Has any Family Member had a Heart Attack, Heart Problems or Sudden Death before before the age of 50? _____ |
| ___ | ___ | 10. Do you wear Glasses, Contacts, or Dental Appliance? _____ |
| ___ | ___ | 11. Do you have any missing or non-functioning organs, such as testes, eye, kidney, etc.? _____ |
| ___ | ___ | 12. Do you have Any Other Significant Health Problems that might be important to a Physician Evaluating your Child in an Emergency? _____ |
| ___ | ___ | 13. Date of Last Tetanus Immunization? _____ |

PARENT / GUARDIAN SIGNATURE - _____ **DATE** _____