

Our Lady of Mount Carmel School

Athletic Participation / Parental Consent / Health History Form

For School Year \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

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

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 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.

Day time(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

**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 miles 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 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** \_\_\_\_\_