ST. ALOYSIUS SPORTS PARTICIPATION FORM

Registration, Consent, Medical Authorization, Acknowledgment, and Waiver

STUDENT'S NAME: ______________________________ BIRTH DATE: ________________ GRADE _____

MOTHER'S (GUARDIAN'S) NAME: ____

MOTHER'S E-MAIL ADDRESS (Most Checked): ____

PHONE: Home No. _________________ Work No. __________________ Cell No. ________________

HOME ADDRESS: ____ Zip Code ____________

FATHER'S (GUARDIAN'S) NAME: ____

FATHER'S E-MAIL ADDRESS (Most Checked): ____

PHONE: Home No. _________________ Work No. __________________ Cell No. ________________

HOME ADDRESS: ____ Zip Code ____________

HEALTH INSURANCE CO. ____ POLICY NO. ______________

ALLERGY OR OTHER PHYSICAL CONDITION: ____

MEDICATION BEING TAKEN: ____

STUDENT'S DOCTOR'S NAME: ___________________________________ PHONE: ________________

PERSON (NON-PARENT) TO CONTACT IN EVENT OF AN EMERGENCY:

NAME: ____ PHONE: ________________

I, the undersigned, consent for my child, named above, to participate one or more of the following sports: boys football, girls volleyball, basketball, cross country, swimming, or track (as applicable). My child has no known physical or other condition that would limit or restrict participation. I will notify the coach or athletic director if there is any change in my child's condition that would limit or restrict my child's participation.

I understand that while participating in a sport, my child may sustain physical illness or injury (minimal, serious, or catastrophic). I further understand that my child is assuming the risk of such physical illness or injury from, but not limited to, falls, contact with other participants, the effects of weather, traffic, and other reasonable risk conditions associated with the sport, and I release St. Aloysius Catholic School, as well as its representatives including the coach, from any claim for any illness or injury that my child may sustain while participating in a sport.

In order that my child may receive the necessary medical treatment for illness or injury sustained while participating in a sport and only in the event that I cannot be reached after a reasonable effort to do so, I authorize the coach to obtain medical treatment for my child for any illness or injury, and I hold the Diocese of Baton Rouge, St. Aloysius Church, and St. Aloysius Catholic School, as well as its representatives including the coach, harmless in exercise of this authority.

I understand that I will be responsible for any medical bills that may be incurred on behalf of my child for physical illness and injury that my child may sustain while participating in a sport. **I certify that my child's activities in any sport is covered by the accident and health insurance named above.**

______________________________ ______________________________

DATE PARENT OR GUARDIAN

ST. ALOYSIUS SPORTS CONTRACT

STUDENT'S NAME: ____________________________ STUDENT'S GRADE ____

As a parent, I request that my child be permitted to participate in school sponsored extracurricular sports. I agree to governed by, cooperate with, and support the rules, regulations, policies, and procedures of the Diocese of Baton Rouge, St. Aloysius Catholic School, and, as applicable, the Catholic School Athletic Association (CSAA), as well as the Student-Parent School Handbook, the Athletics Handbook, and any other provisions published by the school administration. I understand that I am accountable for these rules, regulations, policies, and procedures.

As a parent, I will see that my student fulfills her/his religious and academic responsibilities, including school work and homework assignments, and complies with the rules, regulations, policies, and procedures for sports participation. I will conduct myself in a responsible and mature Christian manner at all times at all practices and contests. I will show respect for authority and will engage in no activity or conduct which in any way is disrespectful, combative, or confrontational, or question the jurisdiction of the pastor, school principal, athletic director, coach, officials, or anyone connected with the conduct of school sports.

As a player, I must fulfill all religious and academic responsibilities to St. Aloysius Catholic School and St. Aloysius Parish, and conduct myself as a committed Christian in school, outside of school, and in particular at any school sports activity. I will comply with rules, regulations, policies, and procedures regarding sports participation.

As player and parent, we acknowledge that a violation of any rule, regulation, policy, or procedure may result in forfeiture of ability to participate in sports. Our signatures mean that we understand and accept these conditions.

Parent/Athlete Concussion Information (from Center on Disease Control - www.cdc.gov/Concussion)
A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by a bump, blow, or jolt to the head or body that causes the head and brain to move rapidly back and forth. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.
In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If an athlete has a concussion, her/his brain needs time to heal. While an athlete's brain is still healing, she/he is much more likely to have another concussion. Repeat concussions can increase the time it takes to recover. In rare cases, repeat concussions in young athletes can result in brain swelling or permanent damage to their brain. *They can even be fatal.*

Concussion Symptoms include

One pupil larger than the other	Drowsiness or cannot be awakened	Slurred speech
A headache that not only does not diminish, but gets worse	Weakness, numbness, or decreased coordination	Increasing confusion, restlessness, or agitation
Repeated vomiting or nausea	Convulsions or seizures	Cannot recognize people or places

Has unusual behavior   Loses consciousness (*even a brief loss of consciousness should be taken seriously*)

What Should You Do If You Think Your Child Has a Concussion? If you suspect that your child has a concussion, remove her/him from play and seek medical attention. Do not try to judge the severity of the injury yourself. Keep the child out of play until a health care professional, experienced in evaluating for concussion, says she/he is symptom-free and it's OK to return to play. Rest is key to recovering from a concussion. Exercising or activities that involve a lot of concentration, such as studying, working on the computer, or playing video games, may cause concussion symptoms to reappear or get worse. After a concussion, returning to sports and school is gradual process that should be carefully managed and monitored by a health care professional.

____________________________ ____________________________

STUDENT SIGNATURE PARENT OR GUARDIAN

MEDICAL HISTORY EVALUATION

IMPORTANT: This form must be completed *annually*, kept on file with the school

Please Print

Name:______________________ School: St. Aloysius ______ Grade:______ Date:________

Sport(s):______________________ Sex: M / F Date of Birth:__________ Age:______

Home Address:____________________ City:______________ State:_____ Zip Code:__________

Parent / Guardian:______________________

FAMILY MEDICAL HISTORY: Has any member of your family under age 50 had these conditions?

Yes	No	Condition	Whom	Yes	No	Condition	Whom	Yes	No	Condition	Whom
☐	☐	Heart Attack/Disease		☐	☐	Sudden Death		☐	☐	Arthritis	
☐	☐	Stroke		☐	☐	High Blood Pressure		☐	☐	Kidney Disease	
☐	☐	Diabetes		☐	☐	Sickle Cell Trait/Anemia		☐	☐	Epilepsy	

ATHLETE'S ORTHOPAEDIC HISTORY: Has the athlete had any of the following injuries?

Yes	No	Condition	Date	Yes	No	Condition	Date	Yes	No	Condition	Date
☐	☐	Head Injury / Concussion		☐	☐	Neck Injury / Stinger		☐	☐	Shoulder L / R	
☐	☐	Elbow L / R		☐	☐	Arm / Wrist / Hand L / R		☐	☐	Back	
☐	☐	Hip L / R		☐	☐	Thigh L / R		☐	☐	Knee L / R	
☐	☐	Lower Leg L / R		☐	☐	Chronic Shin Splints		☐	☐	Ankle L / R	
☐	☐	Foot L / R		☐	☐	Severe Muscle Strain		☐	☐	Pinched Nerve	
☐	☐	Chest									

Previous Surgeries: ______________________

ATHLETE MEDICAL HISTORY: Has the athlete had any of these conditions?

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
☐	☐	Heart Mumur / Chest Pain / Tightness	☐	☐	Asthma / Prescribed Inhaler	☐	☐	Menstrual Irregularities: Last Cycle:______
☐	☐	Seizures	☐	☐	Shortness of breath / Coughing	☐	☐	Rapid weight loss / gain
☐	☐	Kidney Disease	☐	☐	Hernia	☐	☐	Take supplements/vitamins
☐	☐	Irregular Heartbeat	☐	☐	Knocked out / Concussion	☐	☐	Heat related problems
☐	☐	Single Testicle	☐	☐	Heart Disease	☐	☐	Recent Mononucleosi
☐	☐	High Blood Pressure	☐	☐	Diabetes	☐	☐	Enlarged Spleen
☐	☐	Dizzy / Fainting	☐	☐	Liver Disease	☐	☐	Sickle Cell Trait/Anemia
☐	☐	Organ Loss (kidney, spleen, etc)	☐	☐	Tuberculosis	☐	☐	Overnight in hospital
☐	☐	Surgery	☐	☐	Prescribed EPI PEN	☐	☐	Allergies (Food, Drugs)______
☐	☐	Medications______						

List Dates for: Last Tetanus Shot:______________ Measles Immunization:______________ Meningitis Vaccine:______________

PARENTS' WAIVER FORM

To the best of our knowledge, we have given true & accurate information & hereby grant permission for the physical screening evaluation. We understand the evaluation involves a limited examination and the screening is not intended to nor will it prevent injury or sudden death. We further understand that if the examination is provided without expectation of payment, there shall be no cause of action pursuant to Louisiana R.S. 9:2798 against the team volunteer health-care provider and/or employer under Louisiana law.

This waiver, executed on the date below by the undersigned medical doctor, osteopathic doctor, nurse practitioner or physician's assistant and parent of the student athlete named above, is done so in compliance with Louisiana law with the full understanding that there shall be no cause of action for any loss or damage caused by any act or omission related to the health care services if rendered voluntarily and without expectation of payment herein unless such loss or damage was caused by gross negligence. Additionally,

1. If, in the judgment of a school representative, the named student-athlete needs care or treatment as a result of an injury or sickness, I do hereby request, consent and authorize for such care as may be deemed necessary.............. Yes No
2. I understand that if the medical status of my child changes in any significant manner after his/her physical examination, I will notify his/her principal of the change immediately.............. Yes No
3. I give my permission [redacted] to release information concerning my child's injuries to the head coach/athletic director/principal of his/her school.............. Yes No
4. By my signature below, I am agreeing to allow my child's medical history/exam form and all eligibility forms to be reviewed by the CSAA [redacted] or its Representative(s).............. Yes No

______________________ ______________________ ______________________

Date Signed by Parent **Signature of Parent** **Typed or Printed Name of Parent**

II. COMPLETED ANNUALLY BY MEDICAL DOCTOR (MD), OSTEOPATHIC DR. (DO), NURSE PRACTITIONER (APRN) or PHYSICIAN'S ASSISTANT (PA)

Height__________ Weight__________ Blood Pressure__________ Pulse__________

GENERAL MEDICAL EXAM:

	Norm	Abnl
ENT	☐	☐
Lungs	☐	☐
Heart	☐	☐
Abdomen	☐	☐
Skin	☐	☐
Hernia *(If Needed)*	☐	☐

OPTIONAL EXAMS:

VISION:

L:______ R:______ Corrected:______

DENTAL:

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

ORTHOPAEDIC EXAM:

	Norm	Abnl
I. Spine / Neck		
Cervical	☐	☐
Thoracic	☐	☐
Lumbar	☐	☐
II. Upper Extremity		
Shoulder	☐	☐
Elbow	☐	☐
Wrist	☐	☐
Hand / Fingers		
III. Lower Extremity		
Hip	☐	☐
Knee	☐	☐
Ankle	☐	☐

COMMENTS: ______________________

From this limited screening I see no reason why this student cannot participate in athletics.

[ ] Student is cleared
[ ] Cleared after further evaluation and treatment for:___
[ ] Not cleared for: __contact __non-contact

______________________ ______________________ ______________________

Printed Name of MD, DO, APRN or PA **Signature of MD, DO, APRN or PA** **Date of Medical Examination**

Revised 5/14

This physical expires one year on the last day of the month that it was signed and dated by the MD, DO, APRN or PA.