



2011 - 2012 SCHOOL YEAR

Form with fields for NAME, ADDRESS, PARENT(s)/GUARDIAN, MOTHER, FATHER, STUDENT HEALTH INSURANCE PROVIDER, EMERGENCY CONTACT PERSON, and Grade selection.

This section is to be carefully completed by the student parent(s) or legal guardian before participation in interscholastic athletics in order to help detect possible risks.

- Family Medical History: 1. Have you had any injuries since your last physical? 2. Do you have an ongoing medical condition? 3. Has anyone in your immediate family had or have: Diabetes, Asthma, High Blood Pressure, Convulsions, Epilepsy, Migraine Headaches... 4. Has a family member or relative died of heart problems or sudden death before age 50? 5. Does anyone in your family have Marfan syndrome? 6. Has a doctor told you that you or someone in your family has SICKLE Cell trait or SICKLE Cell disease? Cardiovascular: 7. Have you ever passed out or nearly passed out DURING exercise? 8. Have you ever passed out or nearly passed out AFTER exercise? 9. Have you ever had discomfort, pain, or pressure in your chest during exercise? 10. Does your heart race or skip beats during exercise? 11. Has a doctor ever told you that you have: (check all that apply) High Blood Pressure, A Heart Murmur, High Cholesterol, A Heart Infection... 12. Do you have a tendency to bruise easily? 13. Do you have (check all that apply) Asthma, Diabetes, Anemia, Hernia, Kidney Problems, Blood in Urine... 14. Were you born without or are you missing a kidney an eye, a testicle, or any other organ? Infections/Illnesses: 20. Do you have or have you ever had one of the following? Mononucleosis, Hepatitis, HIV or AIDS, Other infectious disease? 21. Do you have any rashes, pressure sores, or other skin problems? Respiratory: 17. Do you have or have you ever had: Hearing loss?, Perforated Ear Drum?, Recurrent Ear Infections?, Sinus Infection?, Fracture/Broken Nose?, Loose or Broken Teeth, Dental Implants? 18. Is there anyone in your family who has asthma? 19. Do you cough, wheeze, or have difficulty breathing during exercise or after exercise? 20. Do you frequently suffer from shortness of breath? 21. Do you frequently have problem of with hyperventilating? 22. Have you ever used an inhaler or taken asthma medication? Heat Problems: 23. Have you ever had problems with exercising in heat or hot weather? 24. When exercising in the heat, do you have severe muscle cramps, or become ill? 25. Have you had episodes of Heat Illness, Dehydration, Heat Exhaustion, Heat Stroke? If yes please explain: Medications: 26. Do you take Medications regularly? If YES, please list: 27. Do you take Medications for EMERGENCY USE? If YES, please list: 28. Are you ALLERGIC to any MEDICATIONS? If YES, please list: 29. Are you ALLERGIC TO INSECT BITES? Specify:

**Orthopedic:**

**YES**      **NO**

- 30. Have you ever had a strain or sprain, muscle pull or tear?
- 31. Have you broken, fractured or dislocated any bones?
- 32. Have you had any problems with pain or swelling in muscles, tendons, bones or joints?
- 33. Have you had a bone or joint injury that required X-Rays, MRI ,CT surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches?

*Check the appropriate box for yes answers to the above questions and explain!*

- |                                |                                    |                                 |                                |                                    |
|--------------------------------|------------------------------------|---------------------------------|--------------------------------|------------------------------------|
| <input type="checkbox"/> Head  | <input type="checkbox"/> Upper Arm | <input type="checkbox"/> Wrist  | <input type="checkbox"/> Hip   | <input type="checkbox"/> Shin/Calf |
| <input type="checkbox"/> Neck  | <input type="checkbox"/> Shoulder  | <input type="checkbox"/> Hand   | <input type="checkbox"/> Thigh | <input type="checkbox"/> Ankle     |
| <input type="checkbox"/> Back  | <input type="checkbox"/> Elbow     | <input type="checkbox"/> Finger | <input type="checkbox"/> Knee  | <input type="checkbox"/> Foot      |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Forearm   |                                 |                                |                                    |

Explain YES answers:

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**Head & Neck Injuries:**

- 34. **Have you ever had a head injury or concussion (Mild Brain Injury)?**  
  - If YES
    - a. Was it necessary to be evacuated to a hospital emergency room?
    - b. Did you see your family physician for this injury?
- 35. **Have you been hit in the head and been confused or lost your memory or lost consciousness?**  

List any and all symptoms experienced: \_\_\_\_\_
- 36. **Have you ever had a seizure or do you have Epilepsy?**
- 37. **Do you have headaches with exercise?**
- 38. **Have you ever had temporary loss of vision after being hit in the head or falling?**
- 39. Do you have impaired vision in:       LEFT EYE       RIGHT EYE
- 40. Have you ever had a neck injury?
- 41. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?
- 42. Have you ever been unable to move your arms or legs after being hit or falling?

- 43. Have you had any illness requiring a physician's services since your last physical for participation in athletics? If YES, please describe and give the date.

- 44. Have you been advised by a physician NOT to participate in any activity with in the last 12 months? If YES, please describe and give date(s).

- 45. Please note any other medical conditions the Sports Medicine Staff should be aware of and/or please give explanations to any questions in which you answered YES .





NAME: \_\_\_\_\_

GRADE: 9 10 11 12

**BY SIGNING BELOW, I/WE CERTIFY THAT:**

**I. PARENTAL CONSENT TO TREAT:**

- A. Permission is hereby granted to the Good Counsel High School Certified Athletic Trainers, Faculty and Coaches to proceed with any necessary Primary and Secondary First Aid. In the event of serious illness or injury I understand that an attempt will be made to contact me in the most expeditious manner possible. If in the event I cannot be reached, the treatment or referral necessary for the best interest of the above-named participant will be given.
- B. Permission is hereby granted to the Good Counsel High School Certified Athletic Trainers to proceed with any necessary evaluation, minor medical treatment, and/or rehabilitation of injuries for the above-named student/athlete.
- C. Permission is hereby granted to the Good Counsel High School Certified Athletic Trainers to proceed with any necessary use of modalities (i.e. Ice, Moist Heat, Ultrasound, Electric Stimulation, T.E.N.S, Light Therapy, Paraffin Bath, Compression Unit, and Whirlpools) for the care, treatment and rehabilitation for the above-named student/athlete's injury(s). All modalities will be used under the direction of the Good Counsel High School Team physician and/or other referring physicians and will only be administered by the Good Counsel High School Certified Athletic Trainers.
- D. **ImPACT Testing:** Permission is granted for the above named student-athlete to participate in completing a Baseline Immediate Post-concussion Assessment & Cognitive Testing (ImPACT). The baseline will be stored in a database for use later should the athlete sustain a head injury, concussion or mild traumatic brain injury (MTBI).

**II. CONSENT TO RECEIVE MEDICATION:**

Permission is hereby granted to the Good Counsel High School Certified Athletic Trainer to distribute medication/topical substances (listed below) to the above-named student athlete. Please indicate if your son/daughter SHOULD NOT have any of the following medications.

Acetaminophen(Tylenol or generic- 500mg)	Gold Bond Powder	New Skin Liquid Bandage
Aleve(220mg)	Heat Aid *	Non-Pseudo Sinus Decongestant***
Afrin Nasal Spray (Oxymetazoline Hydrochlorid)	Hydrocortisone 1.0%, 2.0%,	Pepto Bismol (or generic equivalent)
Bacitracin	Hydrogen Peroxide	Sterile Saline Solution
Benedryl (or generic equivalent) 25mg	Lotrimin 1%	Tuffskin (Adherent Spray)
Betadine Solution (Providone-iodine 10%)	Ibuprofen (generic) 200mg	Tums
Biofreeze (analgesic)	Isopropyl Alcohol	Tylenol (or generic equivalent) 500mg
Cepocol Throat Lozenges	Magonate Liquid (magnesium- 5ml/ 1Tsp)**	Zinc Oxide Ointment
Cough Drops (Halls or generic equivalent)	Mydol (or generic equivalent)	

\*Electrolyte Replenisher \*\*Potassium Chloride, Calcium Phosphate and Magnesium Carbonate (Electrolyte Replenisher) \*\*\*Phenylephrine HCL 10mg

The above-named student should NOT take, is allergic to the following: \_\_\_\_\_

**III. PARENTAL AUTHORIZATION FOR THE USE & DISCLOSURE OF MEDICAL INFORMATION:**

I hereby authorize the Athletic Training Staff to use and disclose our son/daughter's medical information for purposes related to the evaluation, care, and treatment of athletic-related injuries. I understand that I may revoke this authorization at any time, however the revocation will not apply to information that has already been released in response to this authorization. Should I choose to revoke this authorization, I must do so in writing and present my written revocation to the Athletic Training Staff. Unless otherwise revoked, this authorization will be in effect for the entire school year.

**IV. STATEMENT CONCERNING TRANSPORTATION:**

I understand when Our Lady of Good Counsel High School does not provide bus or van transportation; my child will be responsible for arranging his/her own means. I do not hold Our Lady of Good Counsel High School or its faculty or staff responsible for any problems that may arise from these personal arrangements.

**V. STATEMENT OF RISK:**

I acknowledge that Our Lady of Good Counsel High School assumes no responsibility for any risks associated with voluntary participation in school organized athletic, physical education or other activities. Furthermore, I understand that these sports activities involve risk of serious injury or death. After weighing these risks against the potential benefits my son/daughter may gain from these activities, I freely and fully accept the risks of athletics on my child's behalf.

**VI. STATEMENT OF LIABILITY:**

In exchange for the opportunity to participate in interscholastic athletics, I freely and fully waive any claim by me, my spouse or my child, against Our Lady of Good Counsel High School and its employees arising from a sports related injury or from transportation to/from a sporting event.

Additionally, Our Lady of Good Counsel High School's certified athletic trainers and administrators reserve the right to make final decisions regarding a student-athletes participation status.

**By signing below I/we certify that: I/we are in agreement with the statements/authorizations made above, the answers to the questions are true and correct and that I/we understand that having passed the physical examination does not necessarily mean that my child is physically qualified to engage in athletics but only that the examiner did not find medical reason to disqualify him/her at the time of said examination.**

\_\_\_\_\_  
PARENT / GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
Name of Parent/Guardian (Print)

\_\_\_\_\_  
Relation to Athlete