Our Lady of Mount Carmel
Athletic Pre-participation Exam Forms

Parents/Guardian: This pre-participation physical evaluation and consent form is a four page document. Pages one, two, and four require your signature. A physical exam is good for one year from the date of the exam. Please note the area on page 3 requires health care provider signature.

PLEASE RETURN FORMS TO HIGH SCHOOL OFFICE

Athlete:_____ Grade:_____ Sport:_____
Age:____ Gender: _____ Date of Birth: _____ Phone: _____
Parent/Guardian Name: (Please Print)_____
Parent/Guardian Email(s): _____

Parent/Guardian Consents
(Name of Athlete)_____ has my permission to participate in all interscholastic sports NOT checked below.

If you check any sport in this box it means the athlete will **NOT** be permitted to participate in that sport.
___football ___ (B/G)soccer ___ (B/G)volleyball ___ (B/G)cross country ____ (B/G)basketball
___wrestling___cheerleading ___dance ___baseball ___softball ___ (B/G) lacrosse

1. My permission extends to all interscholastic activities whether conducted on or off school premises. The school will provide proper and suitable supervision at practice, games both home and away, and travel supervision while participating in games or practices not held on site at Our Lady of Mount Carmel. Beyond this point of supervision, the school cannot assume responsibility for any injuries.
In exchange for the opportunity to compete in sports, I freely and fully waive any claim by me, my spouse, or my son or daughter against Our Lady of Mount Carmel and its employees arising from sports related injury or transportation to and from sporting events for said participant while participating in the activities not checked above. I have also discussed with him/her and we understand that physical injury, including paralysis, coma or death can occur as a result of participation in interscholastic athletics.

2. To enable Our Lady Mount Carmel and its full and associate member schools to determine whether herein named student is eligible to participate in interscholastic athletics, I hereby consent to the release of any and all portions of school record files, beginning with the ninth grade, of the herein named student, including but not limited to, birth and age records, name and residence of student's parent(s), guardian(s) or Relative Care Giver, residence of student, health records, academic work completed, grades received and attendance records.

3. I further consent to Our Lady of Mount Carmel, the MIAA/IAAM and its full and associate member schools use of the herein named student's name, likeness, and athletically related information in reports of interscholastic practices, scrimmages or contests, promotional literature of the Association, and other materials and releases related to interscholastic athletics.

4. I hereby consent to allow health care providers(s) selected by myself or the schools to perform a pre-participation examination on my child and to provide treatment for any injury received while participating in or training for athletics for his/her school. Permission is also granted for the school athletic trainer, the approved health care provider to proceed with any use of modalities for the care, treatment, and rehabilitation of the above named student who is participating in OLMC athletic events. Modalities will only be utilized under the standing orders of the team orthopedic surgeon, and will only be administered by the certified athletic trainer. I further consent to allow said physician(s) or health care provider(s) to share appropriate information concerning my child that is relevant to participation, with coaches, medical staff, and other school personnel as deemed necessary. Such information maybe used for injury surveillance purposes.

By this signature I agree that I have read and agree to all of the above statements and that my signature authorizes OLMC officials to act in the aforementioned ways.

Parent/Guardian Signature: _____ Date:_____

Pre-participation Physical Evaluation
Our Lady of Mount Carmel

Date of Exam: _____Sport(s):_____

Name:_____Sex: ___Age:___Date of Birth:_____

Address: _____

Grade:_____Personal physician:_____Phone: _____

Explain "Yes" answers below.
Circle questions you don't know the answers to.

	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2. Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	☐
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5. Have you ever passed out or nearly passed out DURING exercise?	☐	☐
6. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
8. Does your heart race or skip beats during exercise?	☐	☐
9. Has a doctor ever told you that you have (check all that apply): ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection		
10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)	☐	☐
11. Has anyone in your family died for no apparent reason?	☐	☐
12. Does anyone in your family have a heart problem?	☐	☐
13. Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
14. Does anyone in your family have Marfan syndrome?	☐	☐
15. Have you ever spent the night in a hospital?	☐	☐
16. Have you ever had surgery?	☐	☐
17. Have you ever had an injury, like a sprain, muscle or ligament tear or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below:	☐	☐
18. Have you had any broken or fractured bones, or dislocated joints? If yes, circle below:	☐	☐
19. 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? If yes, circle below:	☐	☐

Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/ fingers	Chest
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/toes

20. Have you ever had a stress fracture?	☐	☐
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
22. Do you regularly use a brace or assistive device?	☐	☐
23. Has a doctor ever told you that you have asthma or allergies?	☐	☐
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
25. Is there anyone in your family who has asthma?	☐	☐
26. Have you ever used an inhaler or taken asthma medicine?	☐	☐
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
28. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
29. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
30. Have you had a herpes skin infection?	☐	☐
31. Have you ever had a head injury or concussion?	☐	☐
32. Have you been hit in the head and been confused or lost your memory?	☐	☐
33. Have you ever had a seizure?	☐	☐
34. Do you have headaches with exercise?	☐	☐
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
36. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
37. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
39. Have you had any problems with your eyes or vision?	☐	☐
40. Do you wear glasses or contact lenses?	☐	☐
41. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
42. Are you happy with your weight?	☐	☐
43. Are you trying to gain or lose weight?	☐	☐
44. Has anyone recommended you change your weight or eating habits?	☐	☐
45. Do you limit or carefully control what you eat?	☐	☐
46. Do you have any concerns that you would like to discuss with a doctor?	☐	☐
FEMALES ONLY		
47. Have you ever had a menstrual period?	☐	☐
48. How old were you when you had your first menstrual period? _____		
49. How many periods have you had in the last year? _____		

Explain "Yes" answers here: _____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

OLMC PRE-PARTICIPATION PHYSICAL EVALUATION

Name:_____Birthdate:_____

Height:_____Weight:_____%Body fat (optional):_____Pulse:_____

BP:___/___Vision: R 20/_____L20/____Corrected: Y N Pupils: Equal_____Unequal____

Risk behaviors discussed: Y N (diet, weight, driving, drugs, alcohol, sexuality, safety, stress)

	Normal	Abnormal findings	Initials
MEDICAL			
Appearance			
Eyes /ears /nose /throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males)*			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
*Multiple-examiner set-up only *Having 3rd party present is recommended for the genitourinary exam			
Notes			

Please choose one of the following four (4) options:

l. Cleared without restriction: _____

2. Cleared, with recommendations for further evaluation or treatment for:_____

3. *Not Cleared, but needs additional evaluation by (whom):_____

4. Not Cleared for either: _____All sports: _____Certain sports:_____

Reason:_____

Please note any necessary equipment, medications, or restrictions for cleared athlete to play or practice.

By this signature, I hereby state that I have performed a pre-participation examination in accordance with AMSSM standards (current edition of Physician and Sports Medicine's Pre-participation Physical Evaluation) and certify that the above clearance and attached PPE is accurate, complete and compliant to such standards. I also agree that I have documented and signed any playing restrictions on the High School Athlete.

HealthCare Provider's Signature: _____Date:_____

Printed Name:_____Title:_____Phone:_____

Address and/or Physician's Stamp:

Our Lady of Mount Carmel

ATHLETE EMERGENCY CARD

Parents/Guardian: Please take time to FULLY complete this form. It is very important information to have in case of an emergency situation where you cannot be reached. Your child's social security number and insurance information are needed for that purpose only, and will be shared only if absolutely necessary.

Section 1: Contact/Personal Information

Student Name:_____ **Sport:**_____ **SS#:**_____
Student Grade:____ **Birth Date:**____ **Guardian's Name:**_____
Address:_____
Student Phone: (H)_____ **(Cell)**_____
Emergency Contact information:
Mother's Name:_____ **Phone:**_____
Work Phone:_____
Cell Phone:_____
Fathers Name:_____ **Phone:**_____
Work Phone:_____
Cell Phone:_____
Preference of Physician (and permission to contact if needed):
Name:_____ **Phone:**_____
Insurance:_____
Policy No:_____ **Group:**_____ **Phone:**_____

In case of emergency, contact:_____ **Relationship:**_____
Phone: (H)_____ **(W)**_____ **(Cell)**_____

Section 2: Medical Information

Medical Illnesses:_____
Last Tetanus (Mo/Yr):_____ **Allergies:**_____
Medications:_____
(Any Medications That May Be Taken During Competition Require A Physician's Note)
Previous Head/Neck/Back Injury:_____
Previous Heat-Related Problems:_____
Previous Significant Injuries:_____
Any Other Important Medical Information:_____

Section 3: Consent for Athletic Conditioning, Training and Health Care Procedures

I hereby give consent for my child to participate in the school's athletic conditioning and training program and to receive any necessary healthcare treatment including first aid, diagnostic procedures, and medical treatment that may be provided by the treating physicians, nurses, athletic trainers, or other healthcare providers employed directly or through a contract the school, or the opposing team's school. The healthcare providers have my permission to release my child's medical information to other healthcare practitioners and school officials. In the event I cannot be reached in an emergency I give permission for my child to be transported to the nearest emergency room based on local EMS protocols to receive necessary treatment.

Permission to Receive and Release Medical Records

I understand that the Our Lady of Mount Carmel athletic trainer, the approved health care provider for OLMC, may request information regarding the athlete's health status from a physicians office, and I hereby give my permission for the receipt and release of this information as it pertains to my child's ability to safely participate in athletics. In addition should treatment be necessary, I give permission for a physician's office to release medical information to allow for the timely treatment of my child by the approved health care provider for OLMC. This request is to facilitate open communication between the athletic trainer and the treating physician in order to optimize patient care. This information cannot and will not be released to other parties without first being approved by the guardian or parent of the athlete. I understand I will be notified of the necessity of obtaining medical records.

Parent/Guardian Signature:_____ **Date:**_____
Athlete's Signature:_____ **Date:**_____