

**ST. ANTHONY OF PADUA CATHOLIC SCHOOL**  
**CATHOLIC SCHOOLS - ARCHDIOCESE OF GALVESTON HOUSTON**  
**Athletics Program – Parent/Guardian Consent Form**

Parent/Guardian consent, medical history, and physical evaluation are to be completed:

1. Annually
2. Before any practice (both in-season and out-of-season) or games/matches
3. For any student participating in a sport

Student's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_ Sex: \_\_\_\_\_  
Home Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Mom/Guardian: Home #: \_\_\_\_\_ Cell/Pager #: \_\_\_\_\_  
Work Place \_\_\_\_\_ Work #: \_\_\_\_\_  
Father/Guardian: Home #: \_\_\_\_\_ Cell/Pager #: \_\_\_\_\_  
Work Place \_\_\_\_\_ Work #: \_\_\_\_\_  
Name of Insurance Provider: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Dentist's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**MEDICAL INFORMATION**

Date of Student's Last Tetanus Booster Vaccination: \_\_\_\_\_  
Drug Allergies or Other Medical Conditions: \_\_\_\_\_  
In case of Emergency, when the above people can not be located call:  
Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell/Pager #: \_\_\_\_\_  
Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell/Pager #: \_\_\_\_\_

I, \_\_\_\_\_, grant permission for my child \_\_\_\_\_ to participate in extracurricular athletic activities. These activities will take place under the guidance and direction of school employees and/or volunteers. As a parent and/or legal guardian, I remain legally responsible for personal actions taken by the above named minor ("student"). I agree on behalf of myself, my child named herein, our heirs, successors and assigns, to hold harmless and defend St. Anthony of Padua Catholic School, its employees, officers, directors and agents, and the Archdiocese of Galveston-Houston, or representatives associated with these activities, arising from or in connection with my child participating in these activities, or in connection with any illness, injury or cost of medical treatment in connection therewith, and I agree to compensate St. Anthony of Padua Catholic School, its officers, directors and agents, and the Archdiocese of Galveston-Houston, or representatives associated with the activity for reasonable attorney's fees and expenses arising in connection therewith.

I hereby warrant to the best of my knowledge, that my child is in good health, and I assume all responsibility for the health and medical care of my child. In the event of a medical emergency, I hereby give permission to school employees and/or volunteers supervising the athletic event to obtain medical services and to transport my child to the nearest hospital/emergency care center for emergency medical or surgical treatment.

\_\_\_\_\_  
Parent/Guardian Signature                      Relationship                      Date

\_\_\_\_\_  
Print Parent/Guardian Name

**ST. ANTHONY OF PADUA CATHOLIC SCHOOL**  
**CATHOLIC SCHOOLS - ARCHDIOCESE OF GALVESTON HOUSTON**  
**Athletics Program – Medical History Form**

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**The Medical History Form is part of the Athletic Physical and must be presented to the physician at the time of the physical examination.**

**Explain “Yes” answers at end of form. Circle questions for which you don’t know the answers.**

**The student with the help of the parent or guardian is to answer the following questions:**

1. Have you had a medical illness or injury since your last check up or sports physical? Yes\_\_ No\_\_
2. Have you been hospitalized overnight in the past year? Yes\_\_ No\_\_  
Have you had surgery in the past year? Yes\_\_ No\_\_
3. Are you currently taking any prescriptions or non-prescription (over the counter) medication or pills or using an inhaler? Yes\_\_ No\_\_
4. Do you have any allergies (for example, to pollen, medicine, food or stinging insects)? Yes\_\_ No\_\_
5. Have you ever passed out during or after exercise? Yes\_\_ No\_\_  
Have you ever been dizzy during or after exercise? Yes\_\_ No\_\_  
Have you ever had chest pain during or after exercise? Yes\_\_ No\_\_  
Do you get tired more quickly than your friends during exercise do? Yes\_\_ No\_\_  
Have you ever had racing of your heart or skipped heartbeats? Yes\_\_ No\_\_  
Have you ever been told you have a heart murmur? Yes\_\_ No\_\_  
Has any family member or relative died of heart problems or of sudden unexpected death before age 50? Yes\_\_ No\_\_  
Has any family member been diagnosed with enlarged heart, hypertrophic cardiomyopathy, long QT syndrome, Marfan’s syndrome, or abnormal heart rhythm? Yes\_\_ No\_\_  
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? Yes\_\_ No\_\_  
Has a physician ever denied or restricted your participation in sports for any heart problems? Yes\_\_ No\_\_
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? Yes\_\_ No\_\_
7. Have you ever had a head injury or concussion? Yes\_\_ No\_\_  
Have you ever been knocked out, become unconscious, or lost your memory? Yes\_\_ No\_\_  
If yes, how many times? \_\_\_\_ When was the last concussion? \_\_\_\_\_  
How severe was each one? (Explain in the space provided)  
Have you ever had a seizure? Yes\_\_ No\_\_  
Do you have frequent or severe headaches? Yes\_\_ No\_\_  
Have you ever had numbness or tingling in your arms, hands, legs or feet? Yes\_\_ No\_\_  
Have you ever had a stinger, burner, or pinched nerve? Yes\_\_ No\_\_
8. Have you ever become ill from exercising in the heat? Yes\_\_ No\_\_
9. Have you ever gotten unexpectedly short of breath with exercise? Yes\_\_ No\_\_  
Do you cough, wheeze, or have trouble breathing during or after activity? Yes\_\_ No\_\_  
Do you have asthma? Yes\_\_ No\_\_  
Do you have seasonal allergies that require medical treatment? Yes\_\_ No\_\_
10. Have you had any problems with your eyes or vision? Yes\_\_ No\_\_
11. Are you missing any paired organs? Yes\_\_ No\_\_

Medical History Form – Part 2

12. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, and retainer on your teeth, hearing aid?) Yes\_\_ No\_\_

13. Have you ever had a sprain, strain, or swelling after injury? Yes\_\_ No\_\_

Have you broken or fractured any bones or dislocated any joints? Yes\_\_ No\_\_

Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? Yes\_\_ No\_\_

If yes, check the appropriate one and explain below.

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

14. Do you want to weigh more or less than you do now? Yes\_\_ No\_\_

Do you lose weight regularly to meet weight requirements for your sport? Yes\_\_ No\_\_

15. Do you feel stressed out? Yes\_\_ No\_\_

16. Record the dates of your most recent immunizations (shots) or disease for:

Tetanus \_\_\_\_\_ Measles \_\_\_\_\_

Hepatitis B \_\_\_\_\_ Chickenpox \_\_\_\_\_

17. Are you currently under a doctor's care? Yes\_\_ No\_\_

**FOR FEMALES ONLY:**

18. When was your first menstrual period? \_\_\_\_\_

What was your most recent menstrual period? \_\_\_\_\_

How much time do you usually have from the start of one period to the start of another? \_\_\_\_\_

How many periods have you had in the last year? \_\_\_\_\_

What was the longest time between periods in the last year? \_\_\_\_\_

**Explain "Yes" answers here:**

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**Please list all prescribed medication taken by your child:**

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

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Parent/Guardian Name: \_\_\_\_\_

I have reviewed and acknowledge the information in this Medical History Form.

Physician's or Authorized Examiner's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ST. ANTHONY OF PADUA CATHOLIC SCHOOL  
CATHOLIC SCHOOLS - ARCHDIOCESE OF GALVESTON HOUSTON  
Athletics Program – Physical Examination Form**

Student's Name: \_\_\_\_\_ Height: \_\_\_\_ Weight: \_\_\_\_ Pulse: \_\_\_\_ Blood Pressure: \_\_\_\_

Vision R 20/\_\_\_\_ L 20/\_\_\_\_ Corrected: Yes\_\_\_\_ No\_\_\_\_ Pupils: Equal \_\_\_\_ Unequal \_\_\_\_

Hearing: Normal \_\_\_\_ Referred \_\_\_\_ Spinal Exam: Normal \_\_\_\_ Referred \_\_\_\_ % Body Fat (optional)\_\_\_\_

<b>MEDICAL</b>	<b>NORMAL</b>	<b>ABNORMAL FINDINGS</b>	<b>INITIALS</b>
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in the supine			
Heart-Auscultation of the heart in the standing position			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			

**MUSCULOSKELETAL**

Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

**CLEARANCE**

- Cleared for Participation  
 Not cleared for Participation Reason: \_\_\_\_\_

Recommendations and/or Restrictions: \_\_\_\_\_

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, or a Registered Nurse recognized as an Advanced Practiced Nurse by the Board of Nurse Examiners.

Name (print/type): \_\_\_\_\_ Date of Examination: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Signature: \_\_\_\_\_ Title: \_\_\_\_\_