

ARCHBISHOP SPALDING HIGH SCHOOL

Athletic Training Department

Athletic Pre-participation Exam Forms

Parents/Guardian: This pre-participation physical evaluation and consent form is a five page document. Pages one, two four and five require your signature. This physical evaluation must be completed after June 1 of the current year playing sports and runs through June 30 of the following year. **Please note the gray shaded areas on pages 3 and 4 require health care provider signature. All forms should be returned to:**

*****TJ Morgan, ATC***
8080 New Cut Rd.
Severn, MD 21144.**

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

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.

Collision Contact Non-Contact

football (B/G)soccer (B/G)volleyball field hockey (B/G)cross country (B/G) Tennis
 (B/G)basketball wrestling (B/G)swimming (B/G) ice hockey (B/G)indoor track
 cheerleading dance
 baseball softball (B/G) Lacrosse (B/G)outdoor track rugby golf

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 Archbishop Spalding High School. 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 Archbishop Spalding High School 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 Archbishop Spalding High School 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 Archbishop Spalding High School, the MIAA 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. By this signature, I hereby consent to allow the physician(s) and other 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 ASHS 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 ASHS officials to act in the aforementioned ways.

Parent Signature: _____ **Date:** _____

Preparticipation Physical Evaluation Archbishop Spalding High School

Date Of Exam _____ Sport(s) _____

Name _____ Sex _____ Age _____ Date of Birth _____

Address _____

Grade _____ Personal physician _____ Phone _____

In case of emergency, contact _____

Name _____ Relationship _____

Phone (H) _____ (W) _____ (Cell) _____

**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? Yes No
2. Do you have an ongoing medical condition (like diabetes or asthma)? Yes No
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? Yes No
4. Do you have allergies to medicines, pollens, foods, or stinging insects? Yes No
5. Have you ever passed out or nearly passed out DURING exercise? Yes No
6. Have you ever passed out or nearly passed out AFTER exercise? Yes No
7. Have you ever had discomfort, pain, or pressure in your chest during exercise? Yes No
8. Does your heart race or skip beats during exercise? Yes No
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) Yes No
11. Has anyone in your family died for no apparent reason? Yes No
12. Does anyone in your family have a heart problem? Yes No
13. Has any family member or relative died of heart problems or of sudden death before age 50? Yes No
14. Does anyone in your family have Marfan syndrome? Yes No
15. Have you ever spent the night in a hospital? Yes No
16. Have you ever had surgery? Yes No
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: Head Neck Shoulder Upper arm Elbow Forearm Hand/fingers Chest
18. Have you had any broken or fractured bones, or dislocated joints? If yes, circle below: Upper back Lower back Hip Thigh Knee Calf/shin Ankle Foot/toes
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

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? Yes No
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? Yes No
22. Do you regularly use a brace or assistive device? Yes No
23. Has a doctor ever told you that you have asthma or allergies? Yes No

- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| 24. Do you cough, wheeze, or have difficulty breathing during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Is there anyone in your family who has asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Have you ever used an inhaler or taken asthma medicine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Have you had infectious mononucleosis (mono) within the last month? | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Do you have any rashes, pressure sores, or other skin problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Have you had a herpes skin infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Have you been hit in the head and been confused or lost your memory? | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Do you have headaches with exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Have you ever been unable to move your arms or legs after being hit or falling? | <input type="checkbox"/> | <input type="checkbox"/> |
| 37. When exercising in the heat, do you have severe muscle cramps or become ill? | <input type="checkbox"/> | <input type="checkbox"/> |
| 38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. Do you wear glasses or contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 41. Do you wear protective eyewear, such as goggles or a face shield? | <input type="checkbox"/> | <input type="checkbox"/> |
| 42. Are you happy with your weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 43. Are you trying to gain or lose weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 44. Has anyone recommended you change your weight or eating habits? | <input type="checkbox"/> | <input type="checkbox"/> |
| 45. Do you limit or carefully control what you eat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 46. Do you have any concerns that you would like to discuss with a doctor? | <input type="checkbox"/> | <input type="checkbox"/> |

FEMALES ONLY

47. Have you ever had a menstrual period? Yes No
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 _____

Archbishop Spalding High School 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

	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:

1. 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 AAPC and 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.**

Permission to Receive Medication
 _____ Permission is given to the Athletic Training Staff to administer over the counter medications.
 _____ Only Give _____ over the counter medication.
 _____ Do NOT give any over the counter Medications.
LIST ANY MEDICATION NOT TO BE GIVEN: _____
 Parent/Guardian Signature: _____ Date: _____

HealthCare Provider's Signature: _____ Date: _____
 Printed Name: _____ Title: _____ Phone: _____
 *If Option 3 checked then Referred Physician needs to complete below:
 _____ Cleared- no restriction _____ Cleared with the following restrictions: _____
 Not Cleared for ____ All sports ____ Certain sports: _____
 Referred Physician Signature: _____
 Print: _____ Date: _____

SCHOOL ATHLETE MEDICAL CARD

(Parent/Guardian: please print and complete Sections 1, 2 & 3)

Section 1: Contact/Personal Information

Student Name: _____ Sport: _____ SS#: _____
 Student Age: _____ Grade: _____ Birth Date: _____ Guardian's Name: _____
 Address: _____
 Student Phone: (H) _____ Student 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 Holders Name _____
 Policy No. _____ Group/Plan No. _____ Phone _____

Section 2: Medical Information

Medical Illnesses: _____
 Last Tetanus (Mo/Yr: _____ Allergies: _____
 Prescription Medications: _____
 (Any Prescription 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 Archbishop Spalding High School athletic trainer, the approved health care provider for ASHS, 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 ASHS. 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: _____

Section 4: Clearance for Participation

_____ Cleared without restrictions _____ Cleared with the following restrictions:
Health Care Provider's Signature: _____
MD/DO, PA, NP Date: _____

For office use only: This card is valid for one calendar year from date of physical. Note: If any changes occur, a new card should be completed by the parent/guardian. The original card should be kept on file in the school athletic director's or athletic trainer's office. A copy or form with similar information should be kept in the sports' athletic kits. This card contains personal medical information and should be treated as confidential by the school, its employees, agents, and contractors.

Name of School: **Archbishop Spalding High School** Name of ATC: **Mr. Thomas J. Morgan**

Archbishop Spalding High School Athletic Training Dept. Helmet Release Form

Name: _____

THIS IS TO CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE WARNING LABEL AS IT APPEARS ON THE OUTSIDE MY HELMET. THE LABEL READS

FOOTBALL WARNING:

DO NOT STRIKE AN OPPONENT WITH ANY PART OF THIS HELMET OR FACEMASK. THIS IS A VIOLATION OF FOOTBALL RULES AND MAY CAUSE YOU OR YOUR OPPONENT TO SUFFER SEVERE BRAIN OR NECK INJURY.

SEVERE BRAIN OR NECK INJURY MAY ALSO OCCUR ACCIDENTALLY WHILE PLAYING FOOTBALL OR LACROSSE.

NO HELMET CAN PREVENT ALL SUCH INJURIES. YOU USE THIS HELMET AT YOUR OWN RISK.

BASEBALL/SOFTBALL HELMET WARNING:

WARNING

DO NOT USE THIS HELMET IF THE SHELL IS CRACKED OR DEFORMED; OR IF THE INTERIOR PADDING IS DETERIORATED. SEVERE HEAD OR NECK INJURY, INCLUDING PARALYSIS OR DEATH MAY OCCUR TO YOU DESPITE USING THIS HELMET. NO HELMET CAN PREVENT ALL HEAD INJURIES OR ANY NECK INJURIES A PLAYER MIGHT RECEIVE WHILE PARTICIPATING IN BASEBALL OR SOFTBALL

HOCKEY WARNING

WARNING

NO HELMET CAN PREVENT ALL HEAD OR ANY NECK INJURIES A PLAYER MIGHT RECEIVE WHILE PARTICIPATING IN HOCKEY. DO NOT USE THIS HELMET TO BUTT AN OPPOSING PLAYER. THIS IS IN VIOLATION OF THE HOCKEY RULES AND SUCH USE CAN RESULT IN SEVERE HEAD OR NECK INJURIES, PARALYSIS OR DEATH TO YOU AND POSSIBLE INJURY TO YOUR OPPONENT

LACROSSE WARNING

DO NOT USE THIS HELMET IF THE SHELL IS CRACKED OR DEFORMED; OR IF THE INTERIOR PADDING IS DETERIORATED. SEVERE HEAD OR NECK INJURY, INCLUDING PARALYSIS OR DEATH MAY OCCUR TO YOU DESPITE USING THIS HELMET. NO HELMET CAN PREVENT ALL HEAD INJURIES OR ANY NECK INJURIES A PLAYER MIGHT RECEIVE WHILE PARTICIPATING IN LACROSSE.

I ALSO UNDERSTAND THAT FOOTBALL AND LACROSSE ARE POTENTIALLY INJURIOUS SPORTS AND AGREE TO ACCEPT THE RISK OF INJURY ASSOCIATED WITH COMPETITION IN THESE SPORTS. NO HELMET CAN PREVENT ALL SUCH INJURIES.

ATHLETE SIGNATURE: _____ DATE: _____

PARENT SIGNATURE: _____ DATE: _____

PARENT NAME PRINTED: _____