

6.37 DIOCESE OF LITTLE ROCK PAROCHIAL LEAGUE PARENT PERMISSION
Evaluation for Participation in Sports - Pre-Participation Health Examination Record

PART I - STUDENT / ATHLETE INFORMATION (to be completed by parent/guardian prior to examination)

STUDENT NAME _____ SOCIAL SECURITY NUMBER _____
ADDRESS _____ CITY/STATE/ZIP _____
BIRTHDATE _____ AGE _____ SCHOOL/TEACHER _____
RACE: BLACK ___ WHITE ___ OTHER ___ SEX: ___ MALE ___ FEMALE

PARENTS' NAMES _____
ADDRESS _____ CITY/STATE/ZIP _____
PHONE NUMBER _____

PERSON TO CONTACT IN CASE OF EMERGENCY _____
PHONE NUMBER _____
FAMILY DOCTOR _____
CITY/STATE/ZIP _____
PHONE NUMBER _____

This application to compete in interscholastic athletics is entirely voluntary on my part and is made with the understanding that I have not violated any of the eligibility rules and regulations of the Parochial League.

Date Signature of Student

Parent's or Guardian's Permission and Release

I hereby give my consent for the above-named student to represent his or her school in athletic activities except for those indicated on the form by the examining physician. The School Board of Education and its administration/coaches have no responsibility to provide first aid at any of the games and the parent or guardian understands that the risk of injury, or death is assumed by the student and parent when they sign this form. However, in the event physicians, physical therapists, physician's assistants, nurses, or other persons trained in the rendering of first aid are available, as volunteers or otherwise, and render aid to any student injured during the course of any such activities, then the parents do hereby release and forever discharge such persons and the School Board of Education and its administration/coaches from any liability arising out of any first aid or immediate treatment or injuries.

Typed or Printed Name of Parent or Guardian Signature of Parent or Guardian

Address Phone Date

Health History (To be completed by student and parents prior to physician's examination.)

- | | |
|---|--|
| YES NO Has this student had any: | YES NO Is there any history of: |
| 1. _____ Chronic or recurrent illness? | 16. _____ Injuries requiring MD treatment? |
| 2. _____ Illness lasting over 1 week? | 17. _____ Neck injury? |
| 3. _____ Hospitalizations? | 18. _____ Knee injury? |
| 4. _____ Surgery other than tonsillectomy? | 19. _____ Knee surgery? |
| 5. _____ Missing organs (eye, kidney, testicle)? | 20. _____ Ankle injury? |
| 6. _____ Allergy to medication? | 21. _____ Other serious joint injury? |
| 7. _____ Problems with heart or blood pressure? | 22. _____ Broken bone (fracture)? |
| 8. _____ Chest pain with exercise? | 23. _____ Is there any reason why this student should not participate in sports? |
| 9. _____ Dizziness or fainting with exercise? | |
| 10. _____ Dizziness, fainting, frequent headaches, or convulsions other than an accident? | 24. _____ Has any family member died suddenly at less than 40 years of age? |
| 11. _____ Concussion or unconsciousness | 25. _____ Has any family member had a heart attack at less than 55 years of age? |
| 12. _____ Heat exhaustion, heatstroke, or other problems with heat? | |

- YES NO Does this student:
13. _____ Wear eyeglasses or contact lens? 14. _____ Wear dental bridges, braces, plates 15. _____ Take any medication?

Date of last known tetanus (lockjaw) shot: _____
Use this space to explain any of the above numbered YES answers or to provide any additional information:

Students participating in athletics must be covered by insurance. Please fill out:
Name of Insurance _____ Policy No. _____