



Archdiocese of Miami
Department of Schools

Athletic Consent and Release from Liability Certificate

This completed form must be kept on file by the school

Student Name: _____

School: _____ St. Jerome Catholic School _____

Sports in which the student plans to participate: _____

- A. I/we hereby give consent for our child/ward to participate in the interscholastic sports listed above.
- B. I/we know of and acknowledge that my child/ward knows of the risks involved in athletic participation, understands that serious injury, and even death, is possible in such participation and choose to accept any and all responsibility for his/her safety and welfare while participating in athletics. With full understanding of the risks involved, I/we release and hold harmless my child's/ward's school, the school against which it competes, the contest officials and coaches, and the Archdiocese of Miami including all of its affiliated entities and agents of any and all legal responsibility and liability for any injury or claim resulting from such athletic participation and agree to take no legal action against my child's/ward's school, the schools against which it competes, the contest officials and coaches and the Archdiocese of Miami because of any claim, costs, or cause of action arising in any way from the athletic participation of my child/ward. I further authorize emergency medical treatment for my child/ward should the need arise for such treatment while my child/ward is under the supervision of the school.

C. Insurance Information

My/our child is covered under our family health insurance plan which has limits of not less than \$25,000

Company _____ Policy Number: _____

I/WE HAVE READ THIS CAREFULLY AND KNOW IT CONTAINS A RELEASE:

Date: _____ Signature of Parent/Guardian: _____

Date: _____ Signature of Parent/Guardian: _____



Archdiocese of Miami
Office of Catholic Schools
Athletic Pre-participation Physical Evaluation (Page 1 of 2)
This completed form must be kept on file by the school

Part 1. Student Information (to be completed by the parent).

Student Name: _____ Sex: _____ Age _____ Date of Birth _____ / _____ / _____
 School: _____ Grade in School _____ Sport(s) expected to play _____
 Home Address: _____ Home Phone () _____
 Name of Parent/Guardian: _____
 Person to Contact in Case of Emergency: _____
 Relationship to Student: _____ Home Phone: () _____ Work Phone: () _____
 Personal/Family Physician: _____ City/State: _____ Office Phone: () _____

Part 2. Medical History (to be completed by parent). Explain "yes" answers below. Circle questions for which you do not know the answer

	Yes	No		Yes	No
1. Has child had a medical illness or injury since the last check up or sports physical?	_____	_____	26. Has child ever become ill from exercising in the heat?	_____	_____
2. Does child have an ongoing chronic illness?	_____	_____	27. Does child cough, wheeze or have trouble breathing during or after activity?	_____	_____
3. Has child ever been hospitalized overnight?	_____	_____	28. Does child have asthma?	_____	_____
4. Has child ever had surgery?	_____	_____	29. Does child have seasonal allergies that require medical treatment?	_____	_____
5. Is child currently taking any prescription or nonprescription (over the counter) medications or pill or using an inhaler?	_____	_____	30. Does child have 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, retainer on your teeth, hearing aid)?	_____	_____
6. Has child ever taken any supplements or vitamins to help gain or lose weight or improve performance?	_____	_____	31. Has child had any problems with his/her eyes or vision?	_____	_____
7. Does child have any allergies (for example to pollen, medicine, food or stinging insects)?	_____	_____	32. Does child wear glasses, contacts, or protective eye wear?	_____	_____
8. Has child ever had rash or hives develop during or after exercise?	_____	_____	33. Has child ever had a sprain, strain, or swelling after injury?	_____	_____
9. Has child ever passed out during or after exercise?	_____	_____	34. Has child broken or fractured any bones or dislocated any joints?	_____	_____
10. Has child ever been dizzy during or after exercise?	_____	_____	35. Has child had any other problems with pain or swelling in muscles, tendons, bones, or joints?	_____	_____
11. Has child ever had chest pain during or after exercise?	_____	_____	<i>If yes, check appropriate blank and explain below:</i>		
12. Does child get tired more quickly than friends during exercise?	_____	_____	_____ Head	_____ Elbow	_____ Hip
13. Has child ever had racing of the heart or skipped heartbeats?	_____	_____	_____ Neck	_____ Forearm	_____ Thigh
14. Has child had high blood pressure or high cholesterol?	_____	_____	_____ Back	_____ Wrist	_____ Knee
15. Has child ever been told he/she has a heart murmur?	_____	_____	_____ Chest	_____ Hand	_____ Shin/Calf
16. Has any family member or relative died of heart problems or sudden death before age 50?	_____	_____	_____ Shoulder	_____ Finger	_____ Ankle
17. Has child had severe viral infection (for example, myocarditis or mononucleosis) within the last month?	_____	_____	_____ Upper Arm	_____ Foot	
18. Has a physician ever denied or restricted child's participation in sports for any heart problems?	_____	_____	36. Does child want to weigh more or less than child weighs now?	_____	_____
19. Does child have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	_____	_____	37. Does child lose weight regularly to meet weight requirements for a sport?	_____	_____
20. Has child ever had a head injury or concussion?	_____	_____	38. Does child feel stressed out?	_____	_____
21. Has child ever been knocked out, become unconscious, or lost his/her memory?	_____	_____	39. Record the dates of his/most recent immunizations (shots) for:		
22. Has child ever had a seizure?	_____	_____	Tetanus _____	Measles: _____	
23. Does child have frequent or severe headaches?	_____	_____	Hepatitis B _____	Chickenpox: _____	
24. Has child ever had numbness or tingling in his/her arms, hands, legs, or feet?	_____	_____			
25. Has child ever had a stinger, burner, or pinched nerve?	_____	_____			

Explain "Yes" answers here: _____

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

Signature of Parent/Guardian _____

Date: _____



Archdiocese of Miami
Office of Catholic Schools
Athletic Pre-participation Physical Evaluation (Page 2 of 2)
This completed form must be kept on file by the school

Part 3. Physical Examination (to be completed by physician).

Student Name: _____ Date of Birth _____/_____/_____

Height: _____ Weight: _____ % Body Fat (optional): _____ Pulse: _____ Blood Pressure: _____/_____/_____ (_____/_____, ____/____)

Visual Acuity: Right 20/____ Left 20/____ Corrected: Yes No Pupils: Equal _____ Unequal _____

FINDINGS	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
1. Appearance	_____	_____	_____
2. Eyes/Ears/Nose/Throat	_____	_____	_____
3. Lymph Nodes	_____	_____	_____
4. Heart	_____	_____	_____
5. Pulses	_____	_____	_____
6. Lungs	_____	_____	_____
7. Abdomen	_____	_____	_____
8. Skin	_____	_____	_____
MUSCULOSKELETAL			
9. Neck	_____	_____	_____
10. Back	_____	_____	_____
11. Shoulder/Arm	_____	_____	_____
12. Elbow/Forearm	_____	_____	_____
13. Wrist/Hand	_____	_____	_____
14. Hip/Thigh	_____	_____	_____
15. Knee	_____	_____	_____
16. Leg/Ankle	_____	_____	_____
17. Foot	_____	_____	_____

* - Station-based examination only

ASSESSMENT OF EXAMINING PHYSICIAN

____ Cleared without limitation
____ Not cleared for _____ Reason _____
____ Cleared after completing evaluation/rehabilitation for: _____
____ Referred to _____ For _____

Recommendations: _____

Name of Physician (print or type): _____ Date: _____

Address: _____

Signature of Physician: _____, MD, DO, DC, ARNP

ASSESSMENT OF PHYSICIAN TO WHOM REFERRED (if applicable)

I hereby certify that the examination(s) for which referred was/were performed by myself or an individual under my direct supervision with the following conclusion(s)

____ Cleared without limitation
____ Not cleared for _____ Reason _____
____ Cleared after completing evaluation/rehabilitation for: _____
____ Referred to _____ For _____

Recommendations: _____

Name of Physician (print or type): _____ Date: _____

Address: _____

Signature of Physician: _____, MD, DO, DC, ARNP

Based on recommendations developed by the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine and American Osteopathic Academy for Sports Medicine.