Holy Cross Catholic School
Sports Consent

Please read the following statements concerning the participation of your child/ward who will be participating in athletics. Respond below with your signature.

I hereby give my consent for ____ to participate in interscholastic athletics at **HOLY CROSS CATHOLIC SCHOOL**. I also authorize **HOLY CROSS CATHOLIC SCHOOL** to provide the information on the form to the New Mexico Activities Association. The financial responsibility for securing care of athletic injuries is a matter between the parent/guardian and physician or dentist of parent's guardian's selection. **HOLY CROSS CATHOLIC SCHOOL** may not pay doctors, dentists or hospitals for any treatment of any child.

INSURANCE

We have applied for student accident insurance through **HOLY CROSS CATHOLIC SCHOOL**,
☐ YES ☐ NO, or we have accident insurance with the following company:

____

MEDICAL HISTORY

I hereby state that I have reviewed the medical history of my child and find the answers to the questions are correct to the best of my knowledge.

AUTHORIZATION FOR MEDICAL SERVICES

I/We request that I/We be contacted within a reasonable time in the event of illness or injury requiring medical service. In the event we cannot be reached, I/We, parent (s) or guardian (s) hereby designate the Sport Director, Team Coach, Athletic Trainer or his/her designee to act in my/our behalf to authorize such hospitalization, medical attention and surgery as may be required in an emergency because of illness or injuries sustained by my/our behalf to authorize such hospitalization, medical attention and surgery as may be required in an emergency because of illness or injuries sustained by my/our child/ward while participating in school athletics. In the event we cannot be reached, and the situation calls for medical attention, we recognize and relinquish our responsibility to a practicing physician and or medical personnel acting in the best interest of my/our child/ward. I/We hereby assume financial responsibility for hospitalization, medical attention and survey and survey provided.

Family Physician ________________________________ Phone # __________________________
Address ____
Family Dentist __________________________________ Phone # __________________________
Address ____
Hospital Preference ____

Parents/Guardian Phone #
Name __________________________ Home ___________________ Work ____________________
Name __________________________ Home ___________________ Work ____________________
Emergency Contact Phone #
Name __________________________ Home ___________________ Work ____________________
Parent/Guardian Signature ____

MEDICAL HISTORY

This portion is to be completed by **PARENT** or **GUARDIAN** prior to medical examination. This entire form is to be handed over to the Examining Licensed Medical Physical.

Name of Student ________________________________ Grade ___________ DOB _____ Age ____
Address ____

Name of Parent or Guardian ____
Address ____

NOTE TO PARENTS: In order that the best plans may be made for your child, it is necessary that we have your cooperation in filling out this questionnaire accurately before he/she can participate in sports. After conferring with your child, please initial after each sport in which you permit him/her to participate.

☐ Volleyball ☐ Swimming ☐ Basketball ☐ Cheerleading ☐ Soccer
☐ Ski Club ☐ Spirit Team ☐ Cheerleading

Do you want to talk to a doctor about a health problem or injury? ☐ Yes ☐ No
Has anyone in your close family ever had?
- Diabetes (high blood sugar) ☐ Yes ☐ No
- Allergies (hay fever or asthma) ☐ Yes ☐ No
- Migraine Headaches ☐ Yes ☐ No
- Heart Trouble ☐ Yes ☐ No
- High Blood Pressure ☐ Yes ☐ No

Has anyone in your family under age 50 died suddenly? ☐ Yes ☐ No
Have you had or do you now have?
- Brain concussion (head injury) ☐ Yes ☐ No
- Tendency to lose consciousness ☐ Yes ☐ No
- Skull fracture ☐ Yes ☐ No
- Convulsions or epilepsy ☐ Yes ☐ No
- Neck injury ☐ Yes ☐ No

Have you had or do you now have?
- Very bad vision in one eye ☐ Yes ☐ No
- Temporary loss of vision ☐ Yes ☐ No
- To wear glasses or contact lens ☐ Yes ☐ No

Have you had or do you now have?
- Haring Loss ☐ Yes ☐ No
- Perforated ear drum ☐ Yes ☐ No
- Recurrent infections ☐ Yes ☐ No
- Sinus infections ☐ Yes ☐ No
- Broken Nose ☐ Yes ☐ No
- Dental Plate ☐ Yes ☐ No
- Orthodontia ☐ Yes ☐ No

Have you had or do you now have?
- Hernia ☐ Yes ☐ No
- Kidney Problems ☐ Yes ☐ No
- (Boys) Loss of function or absence of testicles ☐ Yes ☐ No
- (Girls) Menstrual problems ☐ Yes ☐ No
- Age of onset of menstruation ☐ Yes ☐ No

Have you had or do you now have?

Bone fracture	☐ Yes ☐ No
Joint Fracture	☐ Yes ☐ No
Foot Problem	☐ Yes ☐ No
Pins, staples or wires in any part of your body	☐ Yes ☐ No
Have you had or do you now have?	
Back injury or frequent headaches	☐ Yes ☐ No
Knee injury (sprain)	☐ Yes ☐ No
Ankle injury (sprain) or recurrent pain	☐ Yes ☐ No
Other joint trouble	☐ Yes ☐ No
Bone infection	☐ Yes ☐ No
Have you had or do you now have?	
Tendency to bleed or bruise easily	☐ Yes ☐ No
Anemia (tired blood)	☐ Yes ☐ No
Weight problem (under or over weight)	☐ Yes ☐ No
Have you had or do you now have?	
Asthma	☐ Yes ☐ No
Hay Fever	☐ Yes ☐ No
Hives or rash	☐ Yes ☐ No
Bee sting reactions (allergy)	☐ Yes ☐ No
Reaction to medication (allergy)	☐ Yes ☐ No
Do you	
Smoke	☐ Yes ☐ No
Take any medication regularly	☐ Yes ☐ No

If **YES** please list medication ____

____

Have you had or do you now have?	
Heart trouble or murmur	☐ Yes ☐ No
High blood pressure	☐ Yes ☐ No
Persistent cough	☐ Yes ☐ No
Chest pain with exercise	☐ Yes ☐ No
Dizziness or faintness with exercise	☐ Yes ☐ No
Have you had or do you now have?	
Recurrent rash	☐ Yes ☐ No
Fungus Infection	☐ Yes ☐ No
Athlete's Foot	☐ Yes ☐ No
Recurrent boils (skin infection)	☐ Yes ☐ No

Do you wish to discuss an emotion problem with the doctor?	☐ Yes ☐ No
Have you ever been told to give up sports because of a health problem?	☐ Yes ☐ No

MEDICAL EXAMINATION

(LICENSED MEDICAL PHYSICIAN ONLY as per NMAA handbook 4.16)

Name of student ______________________________ Grade _____ DOB_______ Age _____

Height __________________ Weight _____________ Blood Pressure ________ Pulse ___________

Eyes Uncorrected R 20/ L 20/ Corrected R 20/ L 20/

	Normal	Abnormal	Remarks
EENT	☐	☐	______________________
Cardiovascular	☐	☐	______________________
Abdomen	☐	☐	______________________
Hernia	☐	☐	______________________
Genitalia	☐	☐	______________________
Musculasketal	☐	☐	______________________
Neurological	☐	☐	______________________
Deformities	☐	☐	______________________
Surgical Scars	☐	☐	______________________
Skin	☐	☐	______________________
Urinalysis (Sugar)	☐	☐	______________________

I certify that I have on this date reviewed the above history and examined this individual and find him/her physically able to compete in interscholastic athletics. **DATE:** ____________________

____
Examining Licensed Medical Physician (Please Print)

____
Signature of Licensed Medical Physician

Address ____

Business Phone: ______________________________________

COMMENTS: