PARENTAL CONSENT

Please read the following statements concerning the participation of your child/ward in interscholastic 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

STUDENT'S INSURANCE: _____ SUBSCRIBER'S NAME: _____
ID NUMBER: _____

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 interscholastic competition sports. After conferring with your child, please initial after each sport in which you permit him/her to participate.

☐ Basketball ☐ Cheerleading ☐ Spirit Team

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?	
Hearing ~~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	No menstruation yet
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: