



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

Medical history questionnaire with 35 numbered questions and a list of body parts for explanation. Questions cover various medical conditions, injuries, and symptoms.

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
Department of Schools

Athletic Consent and Release from Liability Certificate

This completed form must be kept on file by the school

Student Name _____

School _____

Sports in which student plans to participate: _____

A. I/we hereby give consent for child/ward to participate in the interscholastic sports that I have 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 schools against which it competes, the contest officials and the Archdiocese of Miami of any and all 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 the Archdiocese of Miami because of any accident or mishap involving 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: _____



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