



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: _____

Sport(s) in which student plans to participate: _____

- A. I/We hereby give consent for child/ward to participate in the interscholastic sport(s) that I/we have listed above.
- B. I/We know of and acknowledge that my/our 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/our child's/ward's school, the schools against 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/our 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/our child/ward. I/We further authorize emergency medical treatment for my/our child/ward should the need arise for such treatment while my/our child/ward is under the supervision of the school.

C. Insurance Information

My/Our child/ward 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 1. Student Information (to be completed by the parent/guardian).

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: () _____

Part 2. Medical History (to be completed by parent/guardian). 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?	___	___	24. Has child ever had numbness or tingling in his/her arms, hands, legs, or feet?	___	___
2. Does child have an ongoing chronic illness?	___	___	25. Has child ever has a stinger, burner, or pinched nerve?	___	___
3. Has child ever been hospitalized overnight?	___	___	26. Has child ever become ill from exercising in the heat?	___	___
4. Has child ever had surgery?	___	___	27. Does child cough, wheeze or have trouble breathing during or after activity?	___	___
5. Is child currently taking any prescription or nonprescription (over the counter) medications or pill or using an inhaler?	___	___	28. Does child have asthma?	___	___
6. Has child ever taken any supplements or vitamins to help gain or lose weight or improve performance?	___	___	29. Does child have seasonal allergies that require medical treatment?	___	___
7. Does child have any allergies (for example to pollen, medicine, food, or stinging insects)?	___	___	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)?	___	___
8. Has child ever had rash or hives develop during or after exercise?	___	___	31. Has child had any problems with his/her eyes or vision?	___	___
9. Has child ever passed out during or after exercise?	___	___	32. Does child wear glasses, contacts or protective eyewear?	___	___
10. Has child ever been dizzy during or after exercise?	___	___	33. Has child ever had a sprain, strain or swelling after injury?	___	___
11. Has child ever had chest pain during or after exercise?	___	___	34. Has child broken or fractured any bones or dislocated any joints?	___	___
12. Does child get tired more quickly than friends during exercise?	___	___	35. Has child had any other problems with pain or swelling in muscles, tendons, bones, or joints? If yes, check appropriate blanks and explain below:	___	___
13. Has child ever had racing of the heart or skipped heartbeats?	___	___	___ Head	___ Elbow	___ Hip
14. Has child had high blood pressure or high cholesterol?	___	___	___ Neck	___ Forearm	___ Thigh
15. Has child ever been told he/she has a heart murmur?	___	___	___ Back	___ Wrist	___ Knee
16. Has any family member or relative died of heart problems or sudden death before age 50?	___	___	___ Chest	___ Hand	___ Shin/Calf
17. Has child had severe viral infection (for example, myocarditis or mononucleosis) within the last month?	___	___	___ Shoulder	___ Finger	___ Ankle
18. Has a physician ever denied or restricted child's participation in sports for any heart problems?	___	___	___ Upper Arm	___ Foot	
19. Does child have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	___	___	36. Does child want to weigh more or less than child weighs now?	___	___
20. Has child ever had a head injury or concussion?	___	___	37. Does child lose weight regularly to meet weight requirements for a sport?	___	___
21. Has child ever been knocked out, become unconscious, or lost his/her memory?	___	___	38. Does child feel stressed out?	___	___
22. Has child ever had a seizure?	___	___	39. Record the dates of his/her most recent immunizations (shots) for:		
23. Does child have frequent or severe headaches?	___	___	Tetanus _____	Measles _____	
			Hepatitis B _____	Chickenpox _____	

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: _____



Part 3. Physical Examination (to be completed by the 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

_____ Cleared without limitation.

_____ Cleared after completing evaluation/rehabilitation for: _____

_____ Not cleared for: _____ Reason: _____

Recommendations: _____

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

Address: _____

Signature of Physician: _____, MD or DO

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