

**Athletic and Sporting Events  
Parental/Guardian Consent Form and Liability Waiver  
2011-2012 Academic Year**

Student Participant's Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Sex: \_\_\_\_\_

Parent/Guardian's Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business: \_\_\_\_\_ Cell: \_\_\_\_\_

**Request for Permission**

As parent and/or legal guardian, I give permission for my son/daughter named above to participate in interscholastic athletics in the following sports during the 2010-2011 academic year (initial all that apply):

<input type="checkbox"/> Baseball (QC A's/Co-op)	<input type="checkbox"/> Football (Co-op)	<input type="checkbox"/> Volleyball
<input type="checkbox"/> Basketball	<input type="checkbox"/> Golf (Co-op)	<input type="checkbox"/> Wrestling (Co-op)
<input type="checkbox"/> Cheerleading	<input type="checkbox"/> Softball (Dad's Club)	
<input type="checkbox"/> Cross Country	<input type="checkbox"/> Tennis (Co-op)	
<input type="checkbox"/> Dance Team	<input type="checkbox"/> Track & Field (Co-op)	

As parent and/or legal guardian, I remain legally responsible for any personal actions taken by the above named minor ("participant").

I am aware that participating in sports will involve travel to practices and games. I acknowledge and accept the risks involved with my child's travel. I further understand that participation in sports presents to my child the risk of harm, including, but not limited to, serious personal injury or death. Any questions I have concerning my child's participation have been answered.

In consideration of my child being allowed to participate in the sport(s) indicated above, I hereby **RELEASE AND AGREE TO INDEMNIFY AND HOLD HARMLESS** the Catholic Diocese of Peoria, the parish, the school, coaches, chaperones, volunteers or representatives associated with the event, and their employees and agents, from any and all liability for injuries, damages, medical expenses, or any other loss to my child or family or me (including attorneys' fees) arising from or related to my child's participation. Additionally, I give my consent and approval for my child's name and picture to be printed in any sports program, publication, or video.

As a parent/guardian, I further acknowledge that I am a role model. I will remember that school athletics is an extension of the classroom, offering important learning experiences for the students. Therefore, I will show respect for all players, coaches, spectators, and officials. I will only participate in cheers that support, encourage, and uplift the teams involved. I understand the spirit of fair play and good sportsmanship expected by a Catholic school, and accept the responsibility that comes with being a parent/guardian of a student athlete.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## MEDICAL INFORMATION

### Student/Minor

Name (first, middle, last) \_\_\_\_\_  
Address \_\_\_\_\_

### Emergency Contact

Parent(s)/Guardian \_\_\_\_\_  
Name (first, middle, last) \_\_\_\_\_  
Phone (including area code) \_\_\_\_\_

### Other Contact

Name (first, middle, last) \_\_\_\_\_  
Relationship \_\_\_\_\_  
Phone (including area code) \_\_\_\_\_

### Student/Minor's Regular Physician

Name (first, middle, last) \_\_\_\_\_  
Phone (including area code) \_\_\_\_\_

### Medical Conditions

Please list any medical conditions of the above student/minor (asthma, diabetes, epilepsy, etc.)  
\_\_\_\_\_

Please list any allergies or allergic reactions to medications of the above student/minor  
\_\_\_\_\_

Please list any medications the above student/minor is now taking  
\_\_\_\_\_

Date of student/minor's most recent tetanus shot  
\_\_\_\_\_

Other pertinent medical information  
\_\_\_\_\_

### Medical Insurance Information

Company \_\_\_\_\_  
Identification Number of Plan \_\_\_\_\_  
Identification Number of Covered Employee \_\_\_\_\_



Pre-participation Examination

To be completed by athlete or parent prior to examination.

Name Last First Middle Sport/Position School Year
Social Security Number School Year
Address Phone No.
City/State Student ID No.
Birthdate Age Class Student ID No.
Parent's Name
Address
Phone No.
Person to contact in case of emergency
Phone No.
Family Doctor City/State
Phone No.

Past Medical History

- 1. Presently taking medication (including birth control pills)?
2. Have you been diagnosed with asthma?
3. Have you been prescribed by a physician to use any asthma medication?
4. Do you have a current consent form to self-administer the asthma medication on file with your school?
5. Allergic to medicine, foods, bee stings?
6. Wears any appliances - glasses, contact lenses?
7. History of braces, chipped teeth, bridges?
8. Has ongoing medical problem?
9. Had serious or significant illness in past?
10. Any past surgical operations, accidents, non-sports or related injuries?
11. Any past injuries directly related to sports?
12. Any hospitalization not explained above?
13. Any known deformities (such as curvature of back, heart problems, one kidney, blindness in one eye, one testicle, etc.)?
14. Any serious family illness (such as diabetes, bleeding disorders, etc.)?
15. Family history of cancer?
16. Heart
Have you ever passed out during or after exercise?
Have you ever had chest pain during or after exercise?
Do you get tired more quickly than your friends do during exercise?
Have you ever had racing of your heart or skipped heartbeats?

Have you had high blood pressure or high cholesterol?
Have you ever been told you have a heart murmur?
Has any family member or relative died of heart problems or of sudden death before age 50?
Have you had a severe viral infection (for example myocarditis or mononucleosis) within the last month?
Has a physician ever denied or restricted your participation in sports for any heart problems?
Has anyone in your family had a heart attack before the age of 50?
Head and Nerve
Have you ever had a head injury or concussion?
Have you ever been knocked out, become unconscious, or lost your memory?
Have you ever had a seizure?
Do you have frequent or severe headaches?
Have you ever had numbness or tingling in your arms, hands, legs or feet?
Have you ever had a stinger, burner, or pinched nerve?
18. Last tetanus shot?
19. Last eye exam?
20. Last Menstrual period (if women)
Personal Habits
1. Smoking/smokeless tobacco
2. Alcohol/non-medical drugs: marijuana, cocaine, etc.
3. Steroids
4. Eating Disorders - weight loss or gain?
Review of systems (Please check if you have any problems with any of the following areas of your body)
Skin Head Lungs Shoulders, Arms, Hands
Heart Hips, Legs, Feet
Eyes Abdomen Feeling
Nose Back Mental, Emotional
Mouth/Throat Urination, Fatigue
Nutrition, Bowel Control
Weight Control Genital (including menstrual for women)
Neck Other: What?

I certify that the above information is correct to the best of my knowledge.

Student Signature

Parent/Guardian Signature

Both Student and Parent/Guardian Signatures Are Mandatory

### Physical Examination

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_  
 Pulse: resting \_\_\_\_\_ 15 hops \_\_\_\_\_ after 2 minutes resting \_\_\_\_\_  
 Visual Acuity: Eyes (R) 20/\_\_\_\_ w/o glasses \_\_\_\_\_ (L) 20/\_\_\_\_ w/glasses \_\_\_\_\_

Other Testing Normal Abnormal Findings  
 1. General \_\_\_\_\_  
 2. Skin \_\_\_\_\_  
 3. HEENT \_\_\_\_\_  
 4. Teeth (Dental Exam) \_\_\_\_\_  
 5. Neck \_\_\_\_\_  
 6. Lungs \_\_\_\_\_  
 7. Heart (Sit and Stand) \_\_\_\_\_  
 8. Abdomen \_\_\_\_\_  
 9. Genitalia \_\_\_\_\_  
 10. Musculoskeletal \_\_\_\_\_  
 Neck \_\_\_\_\_  
 Shoulder/Arm \_\_\_\_\_  
 Elbow/Forearm \_\_\_\_\_  
 Wrist/Hand \_\_\_\_\_  
 Back \_\_\_\_\_  
 Hip/Thigh \_\_\_\_\_  
 Knee \_\_\_\_\_  
 Shin/Calf \_\_\_\_\_  
 Ankle/Leg \_\_\_\_\_  
 Foot \_\_\_\_\_  
 11. Peripheral Pulses \_\_\_\_\_  
 12. Neurologic \_\_\_\_\_  
 13. Mental Status \_\_\_\_\_  
 14. Marfan Screen \_\_\_\_\_

Other Tests (optional)  
 Auditory \_\_\_\_\_ U/A \_\_\_\_\_ EKG \_\_\_\_\_  
 % Body Fat \_\_\_\_\_ Drug Screen \_\_\_\_\_ Chest X-Ray \_\_\_\_\_  
 Hgb/Hct \_\_\_\_\_ SMAC \_\_\_\_\_ Tanner Stage \_\_\_\_\_

On the basis of the examination on this day, I approve this child's participation in interscholastic sports for one year.

Yes \_\_\_\_\_ No \_\_\_\_\_ Limited \_\_\_\_\_

Additional Comments:

Examination Date \_\_\_\_\_ Physician's Signature \_\_\_\_\_  
 Physician's Assistant Signature\* \_\_\_\_\_  
 Advanced Nurse Practitioner's Signature\* \_\_\_\_\_

\*effective January 2003, the IHSA Board of Directors approved a recommendation, consistent with the Illinois School Code, that allows Physician's Assistants or Advanced Nurse Practitioners to sign off on physicals.

Student's Name \_\_\_\_\_ School Name \_\_\_\_\_

### Consent Form to Self-Administer Asthma Medication

(not needed if current form is already on file with school)

#### Parent Consent

I, \_\_\_\_\_, do hereby give my son/daughter, \_\_\_\_\_, Permission to self-administer his/her asthma medication as prescribed by his/her physician during athletic competition.

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

#### Physician Consent

As a patient under my care, \_\_\_\_\_, is prescribed to self-administer the following asthma medication.

Medication \_\_\_\_\_  
 Purpose \_\_\_\_\_  
 Dosage \_\_\_\_\_  
 Time/Special Circumstances \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

### IHSA Substance Testing Policy Consent to Random Testing

(This section for high school students only)  
**2010-11 school term**

As a prerequisite to participation in IHSA athletic activities, we agree that I/our student will not use performance-enhancing substances as defined in the IHSA Performance-Enhancing Substance Testing Program Protocol. We have reviewed the policy and understand that I/our student may be asked to submit to testing for the presence of performance-enhancing substances in my/his/her body either during IHSA state series events or during the school day, and I/our student do/does hereby agree to submit to such testing and analysis by a certified laboratory. We further understand and agree that the results of the performance-enhancing substance testing may be provided to certain individuals in my/our student's high school as specified in the IHSA Performance-Enhancing Substance Testing Program Protocol which is available on the IHSA website at www.IHSA.org. We understand and agree that the results of the performance-enhancing substance testing will be held confidential to the extent required by law. We understand that failure to provide accurate and truthful information could subject me/our student to penalties as determined by IHSA.

A complete list of the current IHSA Banned Substance Classes can be accessed at [http://www.ihsa.org/initiatives/sportsMedicine/files/IHSA\\_banned\\_substance\\_classes.pdf](http://www.ihsa.org/initiatives/sportsMedicine/files/IHSA_banned_substance_classes.pdf)

Signature of student-athlete \_\_\_\_\_ Date \_\_\_\_\_  
 Signature of parent-guardian \_\_\_\_\_ Date \_\_\_\_\_



## JORDAN SPORTS CONTRACT

Participating in the Jordan School Sports Program is a privilege. This privilege is extended to each student in Jordan Catholic School. The privilege to participate is a combination of understanding, effort and responsibility on the part of the student, parent, coaches, and administration. You are asked to read the attached policies and regulations, abide by them and share in the responsibility of making Jordan sports an enjoyable learning experience for all.

No Jordan student shall be allowed to participate in any Jordan Athletic Program or practice without parent, student and coach signatures.

Student Signature \_\_\_\_\_

Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Coach Signature \_\_\_\_\_

Date \_\_\_\_\_

### INFORMATION

Participant Name \_\_\_\_\_

Medical Insurance \_\_\_\_\_

Emergency # \_\_\_\_\_

Contact Person \_\_\_\_\_

Medications/Special Instructions \_\_\_\_\_

\_\_\_\_\_

**Parents: This contract must be submitted to the Athletic Director within five (5) business days prior to the onset of the athletic event season.**