St. Paul High School 2019 - 2020 Athletic/Co-Curricular Participation Information

Student's Last Name	Student's First Name	Class of	Date of Birth	Authorization Forms on File

Sport or Activity (please check all that apply)

☐ Football ☐ V-ball ☐ Golf ☐ Soccer ☐ Basketball ☐ Track ☐ Baseball ☐ Softball ☐ Cross Country ☐ Cheer ☐ Band

Health History

History of concussion?	Yes	No	If yes, when/described: ______
History of convulsion or seizures?	Yes	No	If yes, when/described: ______
History of fainting?	Yes	No	If yes, when/described: ______
History of rheumatic fever, heart disease, or heart murmur?	Yes	No	If yes, when/described: ______
Has the student ever had a stress fracture or other fracture?	Yes	No	If yes, when/described: ______
Has the student ever had surgery?	Yes	No	If yes, when/described: ______
Is the student missing any organs?	Yes	No	If yes, when/described: ______
Does the student suffer from allergies, asthma, or diabetes?	Yes	No	If yes, when/described: ______
History of high blood pressure?	Yes	No	If yes, when/described: ______
Experienced recent increase/decrease in weight?	Yes	No	If yes, when/described: ______
Is menstruation irregular?	Yes	No	If yes, when/described: ______
Do you know of any reason why the student should not participate in full athletic program?	Yes	No	If yes, when/described: ______

Please explain any "yes" answers or concerns: ______

Height	Weight	Blood Pressure	Pulse	Nose & Throat	Eyes	Conacts or Glasses	Ears	Glands	Teeth	Posture or Orthopedic Conditions
Neurological	Heart	Lungs	Sports Hernia	Hearing	Any findings significant to school					

☐ Cleared without restriction ☐ Cleared with recommendations for further evaluation or treatment for ______

☐ Not cleared for participation in ______ Notes: ______

Name of Physician (print/type/stamp)

______ Date: ______

Address: ______ Phone: ______

Signature of Physician: ______ DC, MD, DO (please circle)

If my child needs to take medication while participating in this activity, I hereby give my child permission to self-administer his/her medication in accordance with the Medication Authorization and Permission Form, and, if my child cannot self-administer, I give permission to the responsible staff members or chaperones to administer or to assist in the administration of my child's medication. I also give permission to the responsible staff members, chaperones, medical practitioners and medical facilities to use their judgement in obtaining and providing medical treatment for my child should it become necessary to do so. I understand that health insurance benefits through the Location, if any, may have limited application, and that I am entirely responsible for the cost of all medical treatment provided to my child. I agree to reimburse the Location for the cost of any medical treatment and related expense incurred. I understand that travel to and from practices and/or contests is by bus or personal vehicle. I hereby release and discharge St. Paul High School from any and all claims for personal injuries or property damage that my student may suffer as a result of participation in the travel whether or not such injuries or damage are caused by negligence of the school or its employees. Release of Liability: As a condition of participating in this activity, I hereby hold harmless, release and discharge The Roman Catholic Archbishop of Los Angeles, a corporation sole, Archdiocese of Los Angeles Education & Welfare Corporation and the Location, their respective agents and employees and any parent/volunteer/ chaperone, from any and all liability, loss or claims for personal injuries, wrongful death or property damage that I or my child may suffer as a result of participation in the activity described above.

Parent/Guardian Signature: ______ Date: ______

Received in office on: ______ by: ______