

**Athletic Training Department**

**Athletic Pre-participation Exam Forms**

Parents/Guardian: This pre-participation consent and insurance form should be filled out by anyone who may participate in interscholastic athletics. Signatures are required in multiple locations by you and your physician. This physical evaluation must be completed after June 1 of the current year playing sports and runs through June 30 of the following year. ***Please note the physician signatures are required on pages 1, 2, and 4. PAGES 1 & 2 GO TO THE SCHOOL NURSE. DO NOT SEND PAGES 1 & 2 TO THE ATHLETIC DEPARTMENT OR ATHLETIC TRAINER. ONLY PAGES 3 & 4 SHOULD BE RETURNED TO THE ATHLETIC TRAINER.***

**\*\*\*TJ Morgan, ATC\*\*\*  
8080 New Cut Rd.  
Severn, MD 21144**

Athlete: \_\_\_\_\_ Grade: \_\_\_\_\_ Sport: \_\_\_\_\_  
Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_  
Parent/Guardian Name: **(Please Print)** \_\_\_\_\_

**Parent/Guardian Consents**

(Name of Athlete) \_\_\_\_\_ has my permission to participate in all interscholastic sports **NOT** checked below.

If you check any sport in this box it means the athlete **will not** be permitted to participate in that sport.

Collision Contact Non-Contact

football  (B/G)soccer  (B/G)volleyball  field hockey  (B/G)cross country  (B/G) Tennis  
 (B/G)basketball  wrestling  (B/G)swimming  (B/G) ice hockey  (B/G)indoor track  
 cheerleading  dance  
 baseball  softball  (B/G) Lacrosse  (B/G)outdoor track  rugby  golf

1. My permission extends to all interscholastic activities whether conducted on or off school premises. The school will provide proper and suitable supervision at practice, games both home and away, and travel supervision while participating in games or practices not held on site at Archbishop Spalding High School. Beyond this point of supervision, the school cannot assume responsibility for any injuries. In exchange for the opportunity to compete in sports, I freely and fully waive any claim by me, my spouse, or my son or daughter against Archbishop Spalding High School and its employees arising from sports related injury or transportation to and from sporting events for said participant while participating in the activities not checked above. I have also discussed with him/her and we understand that physical injury, including paralysis, coma or death can occur as a result of participation in interscholastic athletics.

2. To enable Archbishop Spalding High School and its full and associate member schools to determine whether herein named student is eligible to participate in interscholastic athletics, I hereby consent to the release of any and all portions of school record files, beginning with the ninth grade, of the herein named student, including but not limited to, birth and age records, name and residence of student's parent(s), guardian(s) or Relative Care Giver, residence of student, health records, academic work completed, grades received and attendance records.

3. I further consent to Archbishop Spalding High School, the MIAA and its full and associate member schools use of the herein named student's name, likeness, and athletically related information in reports of interscholastic practices, scrimmages or contests, promotional literature of the Association, and other materials and releases related to interscholastic athletics.

4. By this signature, I hereby consent to allow the physician(s) and other health care providers(s) selected by myself or the schools to perform a pre-participation examination on my child and to provide treatment for any injury received while participating in or training for athletics for his/her school. Permission is also granted for the school athletic trainer, the approved health care provider to proceed with any use of modalities for the care, treatment, and rehabilitation of the above named student who is participating in ASHS athletic events. Modalities will only be utilized under the standing orders of the team orthopedic surgeon, and will only be administered by the certified athletic trainer. I further consent to allow said physician(s) or health care provider(s) to share appropriate information concerning my child that is relevant to participation, with coaches, medical staff, and other school personnel as deemed necessary. Such information maybe used for injury surveillance purposes.

By this signature I agree that I have read and agree to all of the above statements and that my signature authorizes ASHS officials to act in the aforementioned ways.

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**SCHOOL ATHLETE MEDICAL CARD**

(Parent/Guardian: please print and complete Sections 1, 2 & 3)

**Section 1: Contact/Personal Information**  
 Student Name: \_\_\_\_\_ Sport: \_\_\_\_\_ SS#: \_\_\_\_\_  
 Student Age: \_\_\_\_\_ Grade: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Guardian's Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Student Phone: (H) \_\_\_\_\_ **Student Cell** \_\_\_\_\_  
 Emergency Contact information:  
 Mother's Name \_\_\_\_\_ Phone \_\_\_\_\_  
 \_\_\_\_\_ Work Phone \_\_\_\_\_  
 \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Fathers Name \_\_\_\_\_ Phone \_\_\_\_\_  
 \_\_\_\_\_ Work Phone \_\_\_\_\_  
 \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Preference of Physician (and permission to contact if needed):  
 Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Insurance \_\_\_\_\_ Policy Holders Name \_\_\_\_\_  
 Policy No. \_\_\_\_\_ Group/Plan No. \_\_\_\_\_ Phone \_\_\_\_\_

**Section 2: Medical Information**  
 Medical Illnesses: \_\_\_\_\_  
 Last Tetanus (Mo/Yr: \_\_\_\_\_ Allergies: \_\_\_\_\_  
 Prescription Medications: \_\_\_\_\_  
 (Any Prescription Medications That May Be Taken During Competition Require A Physician's Note)  
 Previous Head/Neck/Back Injury: \_\_\_\_\_  
 Previous Heat-Related Problems: \_\_\_\_\_  
 Previous Significant Injuries: \_\_\_\_\_  
 Any Other Important Medical Information: \_\_\_\_\_

**Section 3: Consent for Athletic Conditioning, Training and Health Care Procedures**  
 I hereby give consent for my child to participate in the school's athletic conditioning and training program and to receive any necessary healthcare treatment including first aid, diagnostic procedures, and medical treatment that may be provided by the treating physicians, nurses, athletic trainers, or other healthcare providers employed directly or through a contract the school, or the opposing team's school. The healthcare providers have my permission to release my child's medical information to other healthcare practitioners and school officials. In the event I cannot be reached in an emergency I give permission for my child to be transported to the nearest emergency room based on local EMS protocols to receive necessary treatment.  
**Permission to Receive and Release Medical Records**  
 I understand that Archbishop Spalding High School athletic trainer, the approved health care provider for ASHS, may request information regarding the athlete's health status from a physicians office, and I hereby give my permission for the receipt and release of this information as it pertains to my child's ability to safely participate in athletics. In addition should treatment be necessary, I give permission for a physician's office to release medical information to allow for the timely treatment of my child by the approved health care provider for ASHS. This request is to facilitate open communication between the athletic trainer and the treating physician in order to optimize patient care. This information cannot and will not be released to other parties without first being approved by the guardian or parent of the athlete.  
**I understand I will be notified of the necessity of obtaining medical records.**  
**Permission to Receive Medication**  
 Permission is give to the Athletic Training Staff to administer over the counter medications in accordance with the athletic training department over the counter medication policy. **LIST ANY MEDICATION NOT TO BE GIVEN:** \_\_\_\_\_  
 Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Athlete's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Section 4: Clearance for Participation**  
 \_\_\_\_\_ Cleared without restrictions \_\_\_\_\_ Cleared with the following restrictions:  
**Health Care Provider's Signature:** \_\_\_\_\_  
**MD/DO, PA, NP Date:** \_\_\_\_\_

For office use only: This card is valid for one calendar year from date of physical. Note: If any changes occur, a new card should be completed by the parent/guardian. The original card should be kept on file in the school athletic director's or athletic trainer's office. A copy or form with similar information should be kept in the sports' athletic kits. This card contains personal medical information and should be treated as confidential by the school, its employees, agents, and contractors.