

# ST. IGNATIUS COLLEGE PREPARATORY

2001-37th Avenue ★ San Francisco, California 94116 ★ Phone (415) 731-7500 ★ Fax (415) 682-5077 ★ www.siprep.org

## MEDICAL CLEARANCE & PARENTAL CONSENT FORM "TICKET TO PLAY"

### STUDENT'S INFORMATION (Please Print)

Last Name _____		First Name _____		Middle Name _____			
____ / ____ / ____	Sex (Circle One) M	F	Year in School (Circle One)	9	10	11	12
Date of Birth _____							
Height _____	Weight _____	Age _____	Previous School _____				

### AGREEMENTS & AUTHORIZATION FORM(S)

#### MEDICAL AGREEMENTS & AUTHORIZATION FORM

I understand that in the event of an illness or a serious injury to my child, the on-site administrator will attempt to contact me, or an emergency contact, by calling the phone numbers provided in the school's database. If I cannot be reached and the on-site administrator feels the illness or injury is serious enough to warrant emergency treatment, this person will phone our health care provider, and/or an ambulance, and my child will receive emergency treatment.

I authorize St. Ignatius College Preparatory to transport my child to, and arrange for, emergency medical treatment. I authorize any health care provider to release information of the medical condition of my child to a representative of the school as may be necessary should the health care provider not be able to contact me. This procedure is acceptable to me.

#### ACCEPTANCE OF THE ATHLETICS HANDBOOK

I am aware that participation in the St. Ignatius Athletic Department have some inherent risks and injury can occur. On rare occasions, these injuries can be very serious and life-threatening. In consideration of my child being allowed to participate in the St. Ignatius Athletic Program, I, the parent/guardian, assume the risk of injury and agree not to sue St. Ignatius College Preparatory, The Ignatian Corporation and their respected Officers, Board of Trustees, Regents, Directors, Coaches, Agents, and Volunteers for any and all injuries caused by or resulting from participating in the St. Ignatius Athletic Program.

I have also read and understand the AB 25 Concussion Mandate of Athletes (New Law—2012) located on the St. Ignatius Athletic Website, which states that a student-athlete who is suspected of sustaining a concussion or head injury in a practice or game shall be removed from competition at that time for the remainder of the day. A student-athlete who has been removed from play may not return to play until the athlete is evaluated by a licensed health care provider trained in education and management of concussion and receives written clearance to return to play from that health care provider.

I authorize any health care provider to release information of the medical condition of my child to a representative of the school as may be necessary should the health care provider not be able to contact me.

- By signing below, I have read, understand, and will abide by the policies set forth in the St. Ignatius Athlete & Parent Handbook.
- By signing below, I further understand that St. Ignatius College Preparatory will enforce all rules and regulations contained in the St. Ignatius Athlete & Parent Handbook.
- By signing below, I understand and agree to the procedures in the Medical Agreement & Authorization form.
- By signing below, I agree to keep all medical and contact information up to date with St. Ignatius College Preparatory.

Parent/Guardian Name Printed \_\_\_\_\_ Signed \_\_\_\_\_ Date \_\_\_\_\_  
Parent/Guardian Home Phone \_\_\_\_\_ Parent /Guardian Cell Phone \_\_\_\_\_

Parent/Guardian Name Printed \_\_\_\_\_ Signed \_\_\_\_\_ Date \_\_\_\_\_  
Parent/Guardian Home Phone \_\_\_\_\_ Parent /Guardian Cell Phone \_\_\_\_\_

Student Legal Name Printed \_\_\_\_\_ Signed \_\_\_\_\_ Date \_\_\_\_\_

## MEDICAL INFORMATION - STUDENT'S HISTORY (Please Print)

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

1. Chronic or recurrent illness?	Yes <input type="checkbox"/> No <input type="checkbox"/>	12. Injuries requiring Doctor's treatments?	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Illness lasting over 1 week?	Yes <input type="checkbox"/> No <input type="checkbox"/>	13. Neck or back injury?	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Hospitalization?	Yes <input type="checkbox"/> No <input type="checkbox"/>	14. Knee injury?	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Surgery other than removal of tonsils?	Yes <input type="checkbox"/> No <input type="checkbox"/>	15. Shoulder or elbow injury?	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. Missing organs (eye, kidney, testicle)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	16. Ankle injury?	Yes <input type="checkbox"/> No <input type="checkbox"/>
6. Problems with heart or shortness of breath during exercise?	Yes <input type="checkbox"/> No <input type="checkbox"/>	17. Other serious joint injury?	Yes <input type="checkbox"/> No <input type="checkbox"/>
7. Dizziness or fainting with exercise?	Yes <input type="checkbox"/> No <input type="checkbox"/>	18. Broken bones or fractures?	Yes <input type="checkbox"/> No <input type="checkbox"/>
8. Fainting, bad headaches, or convulsions?	Yes <input type="checkbox"/> No <input type="checkbox"/>	19. Other serious injury?	Yes <input type="checkbox"/> No <input type="checkbox"/>
9. Has any family member had a heart attack at less than 35 years of age?	Yes <input type="checkbox"/> No <input type="checkbox"/>	20. Has any family member died suddenly at less than 40 years of age of causes other than an accident?	Yes <input type="checkbox"/> No <input type="checkbox"/>
10. Heat exhaustion, heatstroke, or other problems with heat?	Yes <input type="checkbox"/> No <input type="checkbox"/>	21. Concussion or loss of consciousness?	Yes <input type="checkbox"/> No <input type="checkbox"/>
11. Wear eyeglasses or contact lenses?	Yes <input type="checkbox"/> No <input type="checkbox"/>	22. Any ongoing medical condition (Asthma, diabetes, etc.)	Yes <input type="checkbox"/> No <input type="checkbox"/>

Explain "Yes" answers here:

\_\_\_\_\_

Doctor's Examination	Normal	Abnormal Findings	Musculoskeletal	Normal	Abnormal Findings
Appearance			Neck		
Eyes/ears/nose/throat			Back		
Hearing			Shoulder/Arm		
Lymph Nodes			Elbow/Forearm		
Heart			Wrist/Hand/Fingers		
Murmurs			Hips/Thighs		
Pulses			Knee		
Lungs			Leg/Ankle		
Abdomen			Foot/Toes		
Genitourinary Skin (males only)					

Explain "Abnormal Findings" answers here:

\_\_\_\_\_

List prescribed medications: \_\_\_\_\_ Time & Dosage of Medications: \_\_\_\_\_

List drug allergies: \_\_\_\_\_ List food allergies: \_\_\_\_\_

- Cleared without restriction.  
 Cleared with the following restrictions/recommendations:

\_\_\_\_\_

\_\_\_\_\_



Doctor Office Official Stamp

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Signature of Physician Mo. Day Year

**Turn in immunization form to the Dean's Office.**

**Note: This form must be turned into the coach on your first tryout or off-season workout.**