

# NOTRE DAME HIGH SCHOOL MEDICAL CARD /CONSENT FORM

ATHLETE: \_\_\_\_\_

MALE: \_\_\_\_\_ FEMALE: \_\_\_\_\_ AGE: \_\_\_\_\_ D-O-B: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

PARENT(S): \_\_\_\_\_

CONTACT PHONE #'S: WORK: \_\_\_\_\_ CELL \_\_\_\_\_

WORK: \_\_\_\_\_ CELL \_\_\_\_\_

## EMERGENCY CONTACT ( in event parents can't be reached):

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

PHONE #'S: HOME: \_\_\_\_\_ WORK: \_\_\_\_\_ CELL: \_\_\_\_\_

DOCTOR: \_\_\_\_\_ PHONE #: \_\_\_\_\_

HEALTH CONCERNS/ALLERGIES: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PARENT(S) INSURANCE CARRIER: \_\_\_\_\_

## SECTION II PARENT PERMISSION/STUDENT AGREEMENT:

### Our signatures indicate:

- ✓ Permission to try out for and participate in interscholastic athletics.
- ✓ Awareness that this form will be sent to Coach and Athletic Director
- ✓ The athlete and/or parent is responsible for notifying coach, AD and School Health office at time of injury.

**PERMISSION FOR EMERGENCY MEDICAL TREATMENT:** In the event of a medical emergency, every effort will be made to contact the parent/guardian to authorize medical treatment/hospitalization. I hereby grant permission for a physician or hospital personnel designated by Notre Dame to attend my son/daughter if I cannot be contacted (Insurance carrier listed above).

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

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

(OVER)

**BATAVIA CITY SCHOOL DISTRICT SPORTS QUESTIONNAIRE**

NAME \_\_\_\_\_ SCHOOL \_\_\_\_\_ SPORT \_\_\_\_\_

**ALL YES ANSWERS MUST BE EXPLAINED.**

- |  | <b>YES</b> | <b>NO</b> |
|--|------------|-----------|
| 1. Have you had a medical illness or injury since your last check-up or sports physical?   | _____      | _____     |
| 2. Have you ever been hospitalized overnight?  | _____      | _____     |
| 3. Have you ever had surgery?  | _____      | _____     |
| 4. Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler?            | _____      | _____     |
| 5. Have you ever taken any supplements or vitamins to help you improve your performance?   | _____      | _____     |
| 6. Do you have any allergies (for example, to pollen, medicine, food or stinging insects)?   | _____      | _____     |
| 7. Have you ever had a rash or hives develop during or after exercise?   | _____      | _____     |
| 8. Have you ever been dizzy or passed out during or after exercise?  | _____      | _____     |
| 9. Have you ever had chest pain during or after exercise?  | _____      | _____     |
| 10. Do you have diabetes?  | _____      | _____     |
| 11. Do you tire more easily than you feel you should?  | _____      | _____     |
| 12. Have you ever been diagnosed with anemia?  | _____      | _____     |
| 13. Have you ever had racing of your heart or skipped heartbeats?  | _____      | _____     |
| 14. Have you had high blood pressure?  | _____      | _____     |
| 15. Have you ever been told you have a heart murmur?   | _____      | _____     |
| 16. Has any family member or relative died of heart problems or of sudden death before age 50?   | _____      | _____     |
| 17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?                             | _____      | _____     |
| 18. Has a physician ever denied or restricted your Participation in sports for any heart problems?                                       | _____      | _____     |
| 19. Have you ever been diagnosed with blood or bleeding disorders?   | _____      | _____     |
| 20. Do you have ONLY one kidney?   | _____      | _____     |
| 21. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, blisters)?                                 | _____      | _____     |
| 22. Have you ever had a head injury or concussion?   | _____      | _____     |
| 23. Have you ever been knocked out, become unconscious, or lost your memory?   | _____      | _____     |
| 24. Have you ever had a seizure or convulsion?   | _____      | _____     |
| 25. Do you have frequent or severe headaches?  | _____      | _____     |
| 26. Have you ever had numbness or tingling in your arms, hands, legs or feet from a stinger, burner or pinched nerve or other condition? | _____      | _____     |

**YES NO**

- |   |       |       |
|---|-------|-------|
| 27. Have you ever had heat cramps, heat exhaustion or heat stroke?  | _____ | _____ |
| 28. Do you cough, wheeze or have trouble breathing during or after activity?  | _____ | _____ |
| 29. Do you have asthma or lung disease?   | _____ | _____ |
| 30. Do you have seasonal allergies that require medical treatment?  | _____ | _____ |
| 31. Do you use any special protective or corrective equipment or devices that are not usually used for your sport or position (for example, knee brace, foot orthotics, retainer on your teeth, hearing aid)? | _____ | _____ |
| 32. Do you wear glasses, contacts or protective eyewear?  | _____ | _____ |
| 33. Do you have any other problem with your eyes or vision?   | _____ | _____ |
| 34. Have you broken or fractured any bones or dislocated any joints or been diagnosed with a stress fracture?   | _____ | _____ |
| 35. Have you ever had a sprain, strain or swelling after injury or any other problems with pain or swelling in muscles, tendons, bones or joints that has kept you from participating in sports?              | _____ | _____ |

**If yes, check appropriate box and explain below.**

- |                 |               |                 |
|-----------------|---------------|-----------------|
| _____ Head      | _____ Elbow   | _____ Hip       |
| _____ Neck      | _____ Forearm | _____ Thigh     |
| _____ Back      | _____ Wrist   | _____ Knee      |
| _____ Chest     | _____ Hand    | _____ Shin/Calf |
| _____ Shoulder  | _____ Finger  | _____ Ankle     |
| _____ Upper Arm |               | _____ Foot      |
- |   |       |       |
|---|-------|-------|
| 36. Do you lose weight regularly to meet weight requirements for your sport?              | _____ | _____ |
| 37. Has there been any unexplained weight loss or weight gain during the past six months? | _____ | _____ |
| 38. Are you currently following any particular diet or weight-reducing plan?              | _____ | _____ |

**FEMALES ONLY**

- |   |       |       |
|---|-------|-------|
| 39. Has there been a recent change in menstrual patterns?   | _____ | _____ |
| 40. At what age did you experience your first menstrual period? _____                             |       |       |
| 41. Last menstrual period? _____ / _____ / _____.   |       |       |
| 42. How much time do you usually have from the start of one period to the start of another? _____ |       |       |
| 43. How many periods have you had in the last year? _____   |       |       |
| 44. What was the longest time between one menstrual cycle and the next in the last year? _____    |       |       |

**EXPLAIN "YES" ANSWERS HERE (Identify each answer with question number)**

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**I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.**

\_\_\_\_\_  
**Signature of Athlete**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Parent/Guardian**

\_\_\_\_\_  
**Date**