

**YOUTH & YOUNG ADULT MINISTRY AND CYO OFFICE – PREPARTICIPATION EXAMINATION FORM**

(PLEASE TYPE OR PRINT)

STUDENT'S NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ SEX \_\_\_\_ GRADE \_\_\_\_  
 LAST FIRST  
 ADDRESS \_\_\_\_\_ PLACE OF BIRTH \_\_\_\_\_  
 STREET CITY ZIP

PARISH \_\_\_\_\_ PARISH CITY \_\_\_\_\_

PARENT(S) NAME \_\_\_\_\_

ADDRESS (IF DIFFERENT THAN STUDENT) \_\_\_\_\_  
 STREET CITY ZIP

WORK TELEPHONE NO. \_\_\_\_\_ HOME TELEPHONE NO. \_\_\_\_\_

FAMILY PHYSICIAN'S NAME, PHONE NUMBER \_\_\_\_\_

- Carefully complete the following questions before your physical exam. Explain "YES" answers below.
- |   | YES | NO  |
|---|-----|-----|
| 1. Has this athlete ever had hospitalization, surgery, injury, serious medical or psychological illness?.....   | ___ | ___ |
| 2. Is this athlete now under the care of a physician or taking any medication?.....   | ___ | ___ |
| 3. Has any physician ever recommended or do you feel that there should be limits placed on participation in competitive sports by this student?.....                      | ___ | ___ |
| 4. Does this athlete have any known allergies? (medication, pollen, food, stinging insects).....  | ___ | ___ |
| 5. Does this athlete wear glasses or contact lenses? Give date of last eye exam if "YES".....   | ___ | ___ |
| 6. Has this athlete ever blacked out, been knocked out, lost consciousness or been dizzy during or after physical activity?.....  | ___ | ___ |
| 7. Has this athlete ever had racing of the heart, skipped heart beat or heart murmur? .....   | ___ | ___ |
| 8. Has this athlete ever had a head injury or concussion?.....  | ___ | ___ |
| 9. Has this athlete ever had a seizure?.....  | ___ | ___ |
| 10. Does this athlete use special protective/corrective equipment that isn't usually used? (For example knee brace, ankle brace, foot orthotics, hearing aid, etc.) ..... | ___ | ___ |
| 11. Does this athlete lose weight regularly to meet weight requirements for the sport?.....   | ___ | ___ |
- Explain any YES answers: \_\_\_\_\_

I/we, the undersigned consent to the participation of the above-named child in CYO athletics including practice sessions and athletic contests. I/we, the undersigned participant/parent, on behalf of myself, my heirs, legatees, and assigns, hereby agree to indemnify, save, and hold harmless the Youth and Young Adult Ministry and CYO Office, the Bishop and Diocese of Cleveland or any of their agents, representatives, employees or assigns for my health, safety or any injury and/or disability arising out of or resulting from: (CHECK all programs that apply)

\_\_\_ CROSS COUNTRY \_\_\_ FOOTBALL \_\_\_ VOLLEYBALL \_\_\_ SOCCER \_\_\_ CHEERLEADING  
 \_\_\_ BASKETBALL \_\_\_ WRESTLING \_\_\_ BASEBALL \_\_\_ SOFTBALL \_\_\_ TRACK & FIELD

As a participant/parent in the program, I/we recognize and acknowledge that there are certain risks or physical injury and I/we agree to assume the full risk of any injuries, including loss of life, damages or loss which I/we may sustain as a result of participating in any and all activities connected with or associated with such program. The undersigned acknowledge that the participant has prepared for the sport in which participating by adequately conditioning and practicing. I/we hereby represent that I have no physical restrictions that would prohibit my participation in the sport that I have selected. The Youth & Young Adult Ministry and CYO Office has my permission to have a physician attend me if deemed necessary during my participation in this CYO program.

I/we further agree to waive and relinquish all claims, fully release and discharge and agree to indemnify and hold harmless and defend the Youth & Young Adult Ministry and CYO Office and its officers, agents, servants and employees from any and all claims resulting from injuries, including loss of life, damages and losses sustained by me and arising out of, connected with, or in any way associated with activities of the program.

Participants Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Parent or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Parent or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

This athlete has family medical insurance: \_\_\_ YES \_\_\_ NO If yes, the Child is covered by:  
 INSURANCE COMPANY: \_\_\_\_\_ POLICY NO. \_\_\_\_\_ EFFECTIVE DATE: \_\_\_\_\_

**HISTORY AND CONSENT MUST BE COMPLETED PRIOR TO PHYSICAL EXAM**

STUDENT'S HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ BP \_\_\_\_\_ PULSE \_\_\_\_\_

	NORMAL	ABNORMAL FINDINGS	INITIALS*
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Muscular skeletal			

OPTIONAL TESTS
URINALYSIS
ALBUMIN _____
SUGAR _____
MICRO (IF ABOVE TEST ABNORMAL)
BLOOD COUNT
(FOR FEMALES)
HGB. _____
OR
HCT. _____

\*Station-based examination only.

SHOULD THERE BE ANY LIMITATIONS PLACED ON ATHLETIC PARTICIPATION? YES \_\_\_ NO \_\_\_

RECOMMENDATIONS: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I certify that I have on this date examined this student and that, on the basis of the examination requested by the CYO authorities and the student's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities. (NOTE EXCEPTIONS IN RECOMMENDATIONS AREA)

PHYSICIAN'S NAME AND ADDRESS (STAMP OR PRINT)
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PHYSICIAN'S SIGNATURE \_\_\_\_\_

PHYSICIAN'S TELEPHONE NO. \_\_\_\_\_ DATE \_\_\_\_\_

**EMERGENCY MEDICAL AUTHORIZATION**

\_\_\_\_\_  
**Student Name**

\_\_\_\_\_  
**Address**

\_\_\_\_\_  
**Telephone**

**Purpose:** To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

**PART I OR II MUST BE COMPLETED  
PART I TO GRANT CONSENT**

In the event reasonable attempts to contact me at \_\_\_\_\_(phone number) or \_\_\_\_\_(other parent or guardian) at \_\_\_\_\_(phone number) have been unsuccessful, I hereby give my consent or: (1) the administration of any treatment deemed necessary by Dr. \_\_\_\_\_(preferred physician) or Dr. \_\_\_\_\_(preferred dentist), or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to \_\_\_\_\_(preferred hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted: \_\_\_\_\_

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Address

**DO NOT COMPLETE PART II IF YOU COMPLETED PART I  
PART II REFUSAL TO CONSENT**

I do not give my consent for emergency medical treatment of my child, in the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to:

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Address

NAME: \_\_\_\_\_  
Last \_\_\_\_\_  
First \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_