Athlete's Name (Last, First): ____

INTERSCHOLASTIC PARTICIPATION FORM

(April 1 or after for current school year!)

Note to parents of students participating in athletics at St. Michael's High School.

St. Michael's High School strives to provide the best possible athletic programs for its students. It wants athletic participation to be a valuable educational experience at all levels. You are requested to read the following carefully and thoroughly, discuss its contents with your child, and present it to your family physician/doctor of osteopathy/physician's assistant/nurse practitioner for his or her approval. This form is to be fully completed and filed at the school BEFORE your child will be allowed to practice and/or compete. This form should be completed only for those students who are planning to participate in interscholastic athletics at any level. We require this physical examination to insure that your child is physically able to participate in athletics and in the event that an accident should occur, that we may notify you in a relatively short period of time.

1. **PARENTAL CONSENT**: We want to be sure that you consent to your child's participation in interscholastic athletics. Therefore, it is necessary that you and your child carefully read and understand the contents of this form along with the expectations of the sport.
2. **MEDICAL HISTORY AND EXAMINATION**: This questionnaire provides a means for the physician/doctor of osteopathy/physician's assistant/nurse practitioner to make reference to previous injury, illness or congenital disorder and also to provide the best possible physical exam for the student athlete.
3. **MEDICAL AUTHORIZATION**: This section provides information to the school for quick reference regarding notification in an emergency situation. Also, it authorizes medical attention in the event parents cannot be reached.
4. **INSURANCE**: The financial responsibility for securing care of athletic injuries is a matter between the parent/guardian and physician/doctor of osteopathy/physician's assistant/nurse practitioner or dentist of the parent's/guardian's selection. It is because of this that St. Michael's High School must have on file the insurance your family has to cover your child in case of an accident. St. Michael's High School offers Student Accident insurance through Guaranteed Trust Life Company. This policy is 24-hour coverage. You may wish to enroll in this through the school. This is strictly on a voluntary basis and is not required if you have sufficient coverage through your own family medical plan. We must have either a form asking for our own school policy or the name of the company through which you are insured.
5. **ELIGIBILITY**: Rules governing eligibility are determined by St. Michael's High School and the New Mexico Activities Association.

Athlete's Name:________________________________ Grade Level: _____ DOB: ____________

(CHECK) □ Male □ Female Birth City/State________________________

Please indicate the sports in which the athlete intends to participate:

✓	Fall (select only one)	✓	Winter (select only one)	✓	Spring (select only one)
	Football		Swim & Dive		Track & Field
	Volleyball		Boys' Basketball		Baseball
	Girls' Soccer		Girls' Basketball		Softball
	Boys' Soccer		Wrestling		Tennis
	Cross Country				Golf
	Cheer & Drill				

MEDICAL EXAMINATION

Name ____ **Gender** ____________ **DOB** _____________

Height ___________ **Weight** ___________ **Blood Pressure** ____________________ **Pulse** ____________

Eyes Corrected
R 20/__________
L 20/ __________

Eyes Uncorrected
R 20/__________
L 20/__________

Pupils: Equal ______ **Unequal** ______

Medical	**Normal**	**Abnormal**	**Findings/Comments**
Appearance			
Eyes/Ears/Nose/Throat			
Hearing			

Heart

Murmurs			
Pulses			
Lungs: Auscultation			
Abdomen			
Genitourinary (if indicated)			
Skin			

Musculoskeletal

Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			

Student MAY participate in the following types of sports (CHECK ALL THAT APPLY):

- ☐ **ALL FORMS OF SPORTS**
- ☐ CONTACT/COLLISION
- ☐ NON-CONTACT/STRENUOUS
- ☐ LIMITED CONTACT/NON CONTACT-STRENUOUS
- ☐ STUDENT CLEARED FOR PARTICIPATION PENDING (explanation)
- ☐ STUDENT NOT CLEARED FOR PARTICIPATION PENDING (explanation)

Name of Physician/Provider (print/type) ____ **Date** ____________

Signature of Physician/Provider ____

Student's Primary Physician/Provider (for follow up if necessary): ___________________________________

TO PARENTS/GUARDIANS AND STUDENT ATHLETES

Please read the following statements concerning the participation of your child/ward in interscholastic athletics. Respond below with your signature.

PARENTAL CONSENT

I hereby give my consent for ____________________________________ to participate in interscholastic athletics at St. Michael's High School and authorize St. Michael's High School to provide the information on the form to the New Mexico Activities Association. The financial responsibility for securing care of athlete's injuries is a matter between the parent/guardian and physician/doctor of osteopathy/physician's assistant/nurse practitioner/or dentist of parent's/guardian's selection.
St. Michael's High School may not pay doctors, dentists or hospitals for treatment of any child.

INSURANCE

Please provide a copy of your insurance card (front and back) attached to this form.

MEDICAL HISTORY

I hereby state that I have reviewed the medical history of my child and find the answers to the questions correct to the best of my knowledge. (*Required for legal minors*.)

AUTHORIZATION FOR MEDICAL SERVICES

I/We request that I/we be contacted within a reasonable time in the event of illness or injury requiring medical service. In the event we cannot be reached, I/we, parent/guardians(s) hereby designate the Athletic Director, Team Coach, Athletic Trainer or his/her designee to act in my/our behalf to authorize in an emergency, due to illness or injuries sustained by my/our child/ward while participating in school athletics. In the event we cannot be reached and the situation calls for medical attention, we recognize and relinquish our responsibility to a practicing physician/doctor of osteopathy/physician's assistant/nurse practitioner and/or medical personnel acting in the best interest of my/our child/ward. I/We hereby assume financial responsibility for hospitalization, medical attention and surgery provided.

Family M.D. /D.O. /PA. /N.P.: ____ **Phone:** _________________

Address: ____ _________________________________

Street ***City*** ***State*** ***Zip***

Family Dentist: ____ **Phone:** ________________

Hospital Preference: ____

Parent/Guardian Telephone: ________________ **Work #:** ______________ **Emergency #:** _____________

Responsible Person: ____

Phone #: _________________________________ **Work #:** __________________________

Signature: ____

MUST HAVE….

1. Physical Exam 2. Copy of Insurance Card 3. Parent/Guardian Signature