



# NOTRE DAME HIGH SCHOOL

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## ATHLETICS

### ATHLETE ACKNOWLEDGEMENT

#### OBEY INSTRUCTIONS, RELEASE ASSUMPTION OF RISK, AND AGREEMENT TO HOLD HARMLESS FOR ATHLETIC PARTICIPATION

Name of Athlete: (Last, First) \_\_\_\_\_ Date: \_\_\_\_\_

Athlete named above is interested in the following sports during the \_\_\_\_\_ school year.

Fall	Winter	Spring
Football <input type="checkbox"/>	Basketball (Boys) <input type="checkbox"/>	Baseball <input type="checkbox"/>
*Cheerleading /Song <input type="checkbox"/>	Cheerleading/Song <input type="checkbox"/>	Softball <input type="checkbox"/>
Water Polo (Boys) <input type="checkbox"/>	Basketball (Girls) <input type="checkbox"/>	Tennis (Boys) <input type="checkbox"/>
Volleyball (Girls) <input type="checkbox"/>	Soccer (Boys) <input type="checkbox"/>	Swimming <input type="checkbox"/>
Cross Country <input type="checkbox"/>	Wrestling <input type="checkbox"/>	Track & Field <input type="checkbox"/>
Tennis (Girls) <input type="checkbox"/>	Water Polo (Girls) <input type="checkbox"/>	Golf <input type="checkbox"/>
	Soccer (Girls) <input type="checkbox"/>	

\* Participation and risk apply to Winter season also

#### ATHLETE ACKNOWLEDGMENT:

I am aware playing or participating to play/participate in any sport can be a dangerous activity involving MANY RISKS OF INJURY. I understand that the dangers and risks of playing or participating to play/participate in the above sport(s) include and are not limited to: death, serious neck and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to virtually all organs, bones, joints, ligaments, tendons, muscles, and other aspects of the muscular and skeletal systems, and serious injury or impairment to other aspects of the body, general health and wellbeing. I understand that the dangers and risks of playing or participating to play/participate in the above sport(s) may result not only in serious injury, but in a serious impairment of my future abilities to earn a living, to engage in other business, social and recreational activities, and generally to enjoy life. Because of the dangers of participating in the above sport(s), I recognize the importance of following coaches' instructions regarding training, playing techniques, and other team rules etc., and agree to obey such instructions.

In consideration of the Catholic Diocese of San Bernardino permitting me to try out for the Notre Dame High School athletic program in the sport or sports checked above and to engage in all activities related to the team(s), including but not limited to: trying out, training, participating or playing in that sport or these sports. I hereby assume all the risks associated with participation and agree to hold the Diocese of San Bernardino, Notre Dame High School, its employees, agents, representatives, coaches, and volunteers harmless from any and all liability, actions, cause of action, debts, claims, or demands, of any kind and nature whatsoever which may arise by or in connection with terms hereof shall serve as a release and assumptions of risk for any heirs, estate, executor, administrator, assignees, and for all members of my family.

The following is to be complete only if the sport you are participating in is football, wrestling or baseball: I specifically acknowledge that these sports I am playing and participating in is/are a VIOLENT CONTACT SPORT(S) involving even greater risk of injury than any other sport(s)	_____ <b>Athlete Initials</b>
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Signature of Athlete: \_\_\_\_\_ Date: \_\_\_\_\_



NOTRE DAME HIGH SCHOOL  
ATHLETICS

**PARENT ACKNOWLEDGEMENT**

**OBEY INSTRUCTIONS, RELEASE ASSUMPTION OF RISK, AND AGREEMENT TO HOLD HARMLESS FOR ATHLETIC PARTICIPATION**

**PARENT/GUARDIAN ACKNOWLEDGMENT:**

I state that I am the parent/guardian of the above-named athlete. I have read the warning and release and understand its terms. I understand that all sports can involve many RISKS OF INJURY, including, but not limited to those risks outlined previously.

In consideration of the Catholic Diocese of San Bernardino permitting me to participate for and/or with the Notre Dame High School athletic program in sport(s) team(s) as indicated and to engage in all activities related to the team(s), including but not limited to: trying out, training, participating or playing in that sport or these sports. I hereby assume all the risks associated with participation and agree to hold the Diocese of San Bernardino, Notre Dame High School, its employees, agents, representatives, coaches, and volunteers harmless from any and all liability, actions, cause of action, debts, claims, or demands, of any kind and nature whatsoever which may arise by or in connection with terms hereof shall serve as a release and assumptions of risk for any heirs, estate, executor, administrator, assignees, and for all members of my family.

<p>The following is to be completed only if the sport your athlete is participating in is football, wrestling or baseball:</p> <p>I specifically acknowledge that _____ my athlete is playing and participating in is/are a Violent Contact Sport(s) involving even greater risk of injury than any other sport(s).</p>	<p>_____ Parent/ Guardian Initials</p>
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Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Athlete: \_\_\_\_\_ Date: \_\_\_\_\_



**NOTRE DAME HIGH SCHOOL**  
**A T H L E T I C S**

**ATHLETE INFORMATION & CONSENT TO PARTICIPATE FORM**

Today's Date: \_\_\_\_\_ School Year: \_\_\_\_\_

Name of Athlete: (Last, First) \_\_\_\_\_

Name of Parent/Legal Guardian: (Last, First) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age as of June 1<sup>st</sup>: \_\_\_\_\_ Year of Graduation: \_\_\_\_\_

**Athlete named above is interested in the following sports (Check all that apply)**

Fall	Winter	Spring
Football <input type="checkbox"/>	Basketball (Boys) <input type="checkbox"/>	Baseball <input type="checkbox"/>
*Cheerleading /Song <input type="checkbox"/>	Cheerleading/Song <input type="checkbox"/>	Softball <input type="checkbox"/>
Water Polo (Boys) <input type="checkbox"/>	Basketball (Girls) <input type="checkbox"/>	Tennis (Boys) <input type="checkbox"/>
Volleyball (Girls) <input type="checkbox"/>	Soccer (Boys) <input type="checkbox"/>	Swimming <input type="checkbox"/>
Cross Country <input type="checkbox"/>	Wrestling <input type="checkbox"/>	Track & Field <input type="checkbox"/>
Tennis (Girls) <input type="checkbox"/>	Water Polo (Girls) <input type="checkbox"/>	Golf <input type="checkbox"/>
	Soccer (Girls) <input type="checkbox"/>	

**ATHLETIC PARENT PERMISSION**

It is with my full knowledge and consent that the above-named athlete participate(s) in the sport(s) and on the team(s) and/or classes of Notre Dame High School as checked above. I further state that I will not hold the Diocese of San Bernardino, Notre Dame High School, or any staff or coach of Notre Dame High School responsible for any injuries received during participation in these sports. Moreover, I recognize that any athlete and myself will be held personally responsible for school property issued during any or all athletic seasons of participation.

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PROGRESS CHECK CONSENT**

I give the Athletic Director, Associate Athletic Director and coaches of Notre Dame High School permission to check the progress of my athlete's classes and programs at any time to ascertain his or her eligibility throughout the season(s) of participation.

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



NOTRE DAME HIGH SCHOOL  
ATHLETICS

**AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR**

I/we, the undersigned parent(s) guardian of:

Name of Athlete: (Last, First) \_\_\_\_\_ Date of Birth: \_\_\_\_\_ do hereby authorize any Physician on the staff of a licensed Hospital or Emergency Clinic, or any other physician designated by him (them) as agent(s) for the undersigned to consent to an X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon on the staff of a licensed Hospital of Emergency Clinic, whether such diagnosis or emergency treatment is rendered at the office of said physician or at said hospital(s). It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician(s) in the exercise of his (their) best judgment may deem advisable.

This authorization shall remain in effect for the \_\_\_\_\_ school year or unless sooner revoked in writing and delivered to the school Principal, Athletic Director, and Athletic Trainer.

This authorization is given pursuant to the provision of Section 25.8 of the Civil Code of California.

\_\_\_\_\_  
Signature of Father/Guardian

\_\_\_\_\_  
Father/Guardian's Address & Phone Number

\_\_\_\_\_  
Signature of Mother/Guardian

\_\_\_\_\_  
Mother/Guardian's Address & Phone Number

Indicate SPECIAL MEDICAL INFORMATION \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Person(s) to be notified in the event parent(s) or guardian(s) cannot be reached:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address & Phone Number

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address & Phone Number



NOTRE DAME HIGH SCHOOL  
ATHLETICS

**ATHLETE EMERGENCY TREATMENT FORM**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Gender: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Address: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

In the event that the parents cannot be reached, list the closest living relatives or other emergency contacts:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Personal Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Insurance Provider: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Personal Dentist: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Insurance Provider: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

List any allergies, previous injuries, current medications, or other medical information:

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

I/We hereby give Notre Dame High School, the Athletic Director, Athletic Trainer, coaches or school staff permission for emergency treatment and also permission to transport to a medical facility or to call emergency transportation (911) in the event of an injury, illness, or other medical emergency for the above-named athlete.

Father's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Mother's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



NOTRE DAME HIGH SCHOOL  
ATHLETICS

**HELMET WARNING FORM**

\*This form is to be completed by football players only

No helmet can prevent all head or neck injuries a player might receive while participating in any practice or contest. Do not use this helmet to butt, ram, or spear an opponent player during a contest or team member practice. This is in violation of the football rules as mandated by the National Federation and State High School Athletic Association. Improper or illegal use of this helmet can result in severe head or neck injuries, paralysis, or death to you and/or opponent.

I certify that I have read and understand the helmet warning stated above.

**Name of Athlete (Last, First):** \_\_\_\_\_

**Signature of Athlete:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Name of Parent/Guardian (Last, First):** \_\_\_\_\_

**Signature of Parent/Guardian (Last, First):** \_\_\_\_\_ **Date:** \_\_\_\_\_

This form should be placed into the athlete's medical file and should **not** be shared with schools or sports organizations.

## ■ PREPARTICIPATION PHYSICAL EVALUATION

### HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Date of examination: \_\_\_\_\_ Sport(s): \_\_\_\_\_

Sex assigned at birth (F, M, or intersex): \_\_\_\_\_ How do you identify your gender? (F, M, or other): \_\_\_\_\_

List past and current medical conditions. \_\_\_\_\_

Have you ever had surgery? If yes, list all past surgical procedures. \_\_\_\_\_

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional). \_\_\_\_\_

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects). \_\_\_\_\_

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of  $\geq 3$  is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

BONE AND JOINT QUESTIONS		
	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS		
	Yes	No
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease?		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (CONTINUED)		
	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
FEMALES ONLY		
	Yes	No
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

**Explain "Yes" answers here.**

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

Signature of athlete: \_\_\_\_\_

Signature of parent or guardian: \_\_\_\_\_

Date: \_\_\_\_\_

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This form should be placed into the athlete's medical file and should **not** be shared with schools or sports organizations.

## ■ PREPARTICIPATION PHYSICAL EVALUATION

### PHYSICAL EXAMINATION FORM

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

#### PHYSICIAN REMINDERS

- Consider additional questions on more-sensitive issues.
  - Do you feel stressed out or under a lot of pressure?
  - Do you ever feel sad, hopeless, depressed, or anxious?
  - Do you feel safe at your home or residence?
  - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
  - During the past 30 days, did you use chewing tobacco, snuff, or dip?
  - Do you drink alcohol or use any other drugs?
  - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
  - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
  - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height:	Weight:	
BP: / ( / )	Pulse:	Vision: R 20/ L 20/ Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance <ul style="list-style-type: none"> <li>Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)</li> </ul>		
Eyes, ears, nose, and throat <ul style="list-style-type: none"> <li>Pupils equal</li> <li>Hearing</li> </ul>		
Lymph nodes		
Heart <sup>a</sup> <ul style="list-style-type: none"> <li>Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)</li> </ul>		
Lungs		
Abdomen		
Skin <ul style="list-style-type: none"> <li>Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis</li> </ul>		
Neurological		
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional <ul style="list-style-type: none"> <li>Double-leg squat test, single-leg squat test, and box drop or step drop test</li> </ul>		

<sup>a</sup> Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of health care professional: \_\_\_\_\_, MD, DO, NP, or PA

The Medical Eligibility Form is the only form that should be submitted to a school or sports organization.

## ■ PREPARTICIPATION PHYSICAL EVALUATION

### MEDICAL ELIGIBILITY FORM

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

- Medically eligible for all sports without restriction  
 Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

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

- Medically eligible for certain sports

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

- Not medically eligible pending further evaluation  
 Not medically eligible for any sports

Recommendations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of health care professional: \_\_\_\_\_, MD, DO, NP, or PA

### SHARED EMERGENCY INFORMATION

Allergies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Emergency contacts: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_