DeMATHA CATHOLIC HIGH SCHOOL

Order of the Most Holy Trinity and of the Captives

UNITED STATES DEPARTMENT OF EDUCATION
TWICE RECOGNIZED SCHOOL OF EXCELLENCE

Athletic Department

RELEASE OF MEDICAL INFORMATION

Baseball

Basketball

Crew

Cross Country

Football

Golf

Hockey

Lacrosse

Rugby

Soccer

Swimming

Tennis

Track
Indoor
Outdoor

Wrestling

Parent/Guardian Information (Complete if Student is a minor)			
Parent/Guardian Print Name:			
Parent/Guardian Mobile #:		Email address:	
Preferred method of contact:			
Student Information			
Student Print Name:			
Home Address:			
City:		County:	
Zip Code:		Date of Birth:	

Information to be Released by School: By signing below you authorize the DeMatha medical personnel to release health and medical information regarding your child, including but not limited to your child's medical care and management protocols to DeMatha's administrators, faculty, counseling staff, coaches, other officials, and field trip chaperones as necessary and appropriate to enable school employees to address your child's medical needs or care in an emergency situation.

How long is this consent valid? This consent form is valid through the end of the 2024-2025 academic school year, unless you provide written notice to DeMatha that you wish to revoke your consent.

Can I revoke this consent? You have the right to revoke this consent form at any time by delivering a written notice to the DeMatha medical personnel. Your revocation will be effective upon receipt but will not affect any release of information that occurs prior to receipt.

By signing below, I agree that:

- I have read and understand the information in this release of information form. DeMatha has answered any questions I have about this form.
- I understand that if I am age 18 or older, or may otherwise legally consent for my own health care, references to "my child" refer to me and I may sign this form on my own behalf.
- I understand and agree that my child's health-related information may be shared with DeMatha officials and staff as described in this form.

Parent/Guardian Signature: _____

Student Signature (if age 18 or older): _____

Printed Name: _____ **Date:** _____

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE

CHILD'S NAME _____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE ____/____/____

COUNTY _____ SCHOOL _____ GRADE _____

PARENT OR GUARDIAN NAME _____ PHONE NO. _____

ADDRESS _____ CITY _____ ZIP _____

RECORD OF IMMUNIZATIONS (See Notes On Other Side)

Vaccines Type

Dose #	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/Yr
1									1				
2									2				
3										Td Mo/Day/Yr	Tdap Mo/Day/Yr	FLU Mo/Day/Yr	Other Mo/Day/Yr
4													
5													

To the best of my knowledge, the vaccines listed above were administered as indicated.

Clinic / Office Name
Office Address/ Phone Number

1. _____
Signature Title Date
(Medical provider, local health department official, school official, or child care provider only)

2. _____
Signature Title Date

3. _____
Signature Title Date

Lines 2 and 3 are for certification of vaccines given after the initial signature.

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM VACCINATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY VACCINATION(S) THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:

Please check the appropriate box to describe the medical contraindication.

This is a: ☐ Permanent condition OR ☐ Temporary condition until ____/____/____
Date

The above child has a valid medical contraindication to being vaccinated at this time. Please indicate which vaccine(s) and the reason for the contraindication, _____

Signed: _____ Date _____
Medical Provider / LHD Official

RELIGIOUS OBJECTION:

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any vaccine(s) being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: _____ Date: _____

PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____ Grade _____

- Do you feel stressed out or under a lot of pressure?
- Do you feel safe at your home or residence?
- Do you ever use cigarettes, chewing tobacco, snuff, or dip?
- Do you drink alcohol or use any other drugs?
- Do you ever feel sad, hopeless, depressed, or anxious?
- Do you wear a seat belt, use a helmet, and use condoms?

Have you in the past 30 days?

- Have you ever taken anabolic steroids or used any other performance supplement?
- Have you ever taken any supplements to help you gain or lose weight or improve your performance?

EXAMINATION		
Height Weight BP / Pulse		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph Nodes		
Heart • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses (Simultaneous femoral and radial pulses)		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin (HSV, lesions suggestive of MRSA, tinea corporis)		
Neurologic		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Fingers/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/toes		
Functional (Duck-walk, single leg hop)		

- ○ Cleared for all sports without restriction
- ○ Cleared for all sports without restriction with recommendations for further evaluation or treatment for: _____
  _____
- ○ Limited Participation: _____
- ○ Clearance withheld until: _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is 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 clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of Physician (print/type) _____ Date _____

Signature of Physician _____ Phone _____

HISTORY FORM

Name _____ Birthdate _____ Grade _____

Sport(s) playing at DeMatha _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking _____

Please list any allergies? _____

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: • Asthma • Anemia • Diabetes • Infections Other: _____		
3. Have you ever been diagnosed with a learning disability?		
4. Have you ever been diagnosed with ADD or ADHD?		
5. Have you ever received treatment for anxiety, depression, or any other mental illnesses?		
6. Have you ever spent the night in the hospital?		
7. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
8. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
9. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
10. Does your heart ever race, skip or feel irregular during exercise?		
11. Has a doctor ever told you that you have any heart problems? If so, circle all that apply: • High blood pressure • A heart murmur • High cholesterol • A heart infection • Kawasaki disease Other: _____		
12. Has a doctor ever ordered a test for your heart? (ECG/EKG, echocardiogram, etc.)		
13. Do you get lightheaded or feel more short of breath than expected during exercise?		
14. Have you ever had an unexplained seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
15. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
16. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
17. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
18. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	Yes	No
19. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
20. Have you ever broken or fractured bones or dislocated joints?		
21. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
22. Have you ever had a stress fracture?		
23. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
24. Do you regularly use a brace, orthotics, or other assistive device?		
25. Do you have a bone, muscle, or joint injury that bothers you?		
26. Do any of your joints become painful, swollen, feel warm, or look red?		
27. Do you have any history of juvenile arthritis or connective tissue disease?		
MEDICAL QUESTIONS	Yes	No
28. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
29. Have you ever used an inhaler or taken asthma medicine?		
30. Is there anyone in your family who has asthma?		
31. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
32. Do you have groin pain or a painful bulge or hernia in the groin area?		
33. Have you had infectious mononucleosis (mono) within the last month?		
34. Do you have any rashes, pressure sores, or other skin problems?		
35. Have you had a herpes or MRSA skin infection?		
36. Have you ever had a head injury or concussion?		
37. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
38. Do you have a history of seizure disorder?		
39. Do you have seizures uncontrollable by medications?		
40. Do you have headaches with exercise?		
41. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
42. Have you ever been unable to move your arms or legs after being hit or falling?		
43. Have you ever become ill while exercising in the heat?		
44. Do you get frequent muscle cramps when exercising?		
45. Do you or someone in your family have sickle cell trait or disease?		
46. Have you had any problems with your eyes or vision?		
47. Have you had any eye injuries?		
48. Do you wear glasses or contact lenses?		
49. Do you wear protective eyewear, such as goggles or a face shield?		
50. Do you worry about your weight?		
51. Are you trying to or has anyone recommended that you gain or lose weight?		
52. Are you on a special diet or do you avoid certain types of foods?		
53. Have you ever had an eating disorder?		
54. Do you have a bleeding condition or bleed easily?		
55. Do you have any concerns that you would like to discuss with a doctor?		

Explain "yes" answers: _____

_____

_____

_____

_____

_____

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

Student Signature _____ Date _____

Guardian Signature _____ Date _____

STUDENT ATHLETE EMERGENCY FORM

Name _____ Birthdate _____ Grade _____

Parent/Guardian Name(s) _____

Home Address _____

Athlete Resides with: _____ Mother _____ Father _____ Both _____ Other

Contact Phone Number #1 _____ Email address: _____

Contact Phone Number #2 _____ Email address: _____

Emergency contact if guardian cannot be reached: _____

Allergies: _____ Current Medications: _____

Any notable medical problem we need to be aware of: _____

I hereby give permission to a physician, athletic trainer, or medical center to provide medical services to my child.

Signature _____ Date _____

If my child is sick or incurs an injury, I give permission to the athletic trainer to administer over the counter medications and topicals (including but not limited to ibuprofen, acetaminophen, cold remedies, diphen, triple antibiotic ointment).

Signature _____ Date _____

INSURANCE INFORMATION

Students are not allowed to participate on interscholastic teams without health insurance.

Insurance company name _____ Insurance co phone number _____

Insurance co address _____

Insurance is provided through (employer's name) _____

Policy holder's name _____ Policy Holder's Date of Birth: _____

Policy # _____ Member ID/Group # _____

Authorization to release benefits to medical center/hospital

Signature _____ Date _____

STUDENT PARTICIPATION AND PARENTAL APPROVAL

THIS APPLICATION TO COMPETE IN INTERSCHOLASTIC ATHLETICS IS ENTIRELY VOLUNTARY ON MY PART AND IS MADE WITH THE UNDERSTANDING THAT I HAVE NOT VIOLATED ANY OF THE ELIGIBILITY RULES/REGULATIONS OF DEMATHA AND THE WCAC

Participation in high school athletics has many rewards and can provide tremendous enjoyment. However, it is important for both the participant and his parents to realize that an element of physical risk is present when one is involved in athletics. The purpose of this statement is to clarify the school's position in terms of insurance coverage and to obtain your permission to treat him medically if your son should be injured.

DeMatha's insurance coverage, like that of all schools, does not cover personal injury that is the result of athletic participation. You must provide your own health insurance for athletic participation. It is important that you check with your own insurance carrier to be certain that athletic injury for your son is covered by your policy. If a family does not provide insurance coverage, a student is not eligible to participate on school interscholastic athletic teams. The school's insurance policy does cover injury that would result from an accident incurred with school transportation going to and from practice or game sites. Students who chose to provide their own transportation must carry their own insurance coverage. Likewise, students and/or parents who volunteer to transport others to and from practice and/or game sites are not covered by school insurance.

Acknowledging and understanding this: "I hereby give my consent to the above named student to represent his school in athletic activities for which the attending physician has given medical clearance; to accompany any school team of which he is a member to any of its local or out of town trips. I authorize school personnel (coaches, athletic trainer) to obtain, through a physician of their own choice, any emergency medical care that may become necessary for the student in the course of such athletic activities or such travel. I understand and agree that I am the responsible party for any medical expenses that may occur from such an emergency or any medical care given. I also agree to not hold the school or anyone acting in its behalf responsible for any injury occurring to the above named student in the course of such athletic participation or travel."

Signature _____ Date _____

Athlete Signature _____ Date _____

ONE DEMATHA

I, _____, parent of _____
have visited the sites and read the information under the section "Safety Concerns For Parents To Consider" on the DeMatha Athletic webpage. I understand that the information presented can help me keep my son safe and healthy while participating in athletics at DeMatha.

Parent Signature _____ Date _____

safe sports school
NATIONAL ATHLETIC TRAINERS' ASSOCIATION