DIOCESAN MIDDLE SCHOOL ATHLETIC ASSOCIATION

PARENT(S) OR GUARDIAN(S) PERMISSION AND INFORMED CONSENT

School St Pius X Catholic School Grade Sex

I hereby give my consent to the student whose name appears on this physical form to represent his/her school in interscholastic activities, except those activities crossed out on the form by the examining physician. I also give my consent for him/her to accompany the team as a member on its out-of-town trips, and I will not hold the school or DMSAA responsible in case of accidents or injuries.

Student athletes should be aware of the possibility of injury when participating in athletics. Therefore, all students and parents must read the *Informed Consent* below and sign their names to the statement.

I approve and hereby grant permission for my son/daughter to participate in interscholastic athletics under the above conditions. I also give my consent for the information contained within these Diocesan forms to be shared with all those who work with my son/daughter.

I realized there is an inherent risk of injuries in all sports for my child, _____. I understand the risk of injury may be severe, including risk of fractures, brain injuries, paralysis, or even death.

It is my responsibility as parent/guardian to provided primary insurance coverage.

_____

Signature of Parent or Guardian

_____

Signature of Student

NOTE: The Diocesan Middle School Athletic Association (DMSAA) requires that his form be completed and filed in the office of the principal before the student is allowed to practice and/or compete.

DIOCESAN MIDDLE SCHOOL ATHLETIC ASSOCIATION
AUTHORIZATION FOR EMERGENCY CARE TO MINOR

I, the undersigned parent with legal custody or legal guardian of the minor listed below:

Minor's Name _____ School _____

Address _____ Phone _____

Date of Birth _____ Allergies _____

Health Problem(s) _____

Last Tetanus Shot (mo/day/yr) _____ Insurance _____

Preferred Doctor/Address _____ Phone _____

Preferred Dentist/Address _____ Phone _____

Preferred Hospital/Address _____ Phone _____

Do hereby authorize any x-ray examination, anesthetic, dental or medical or surgical diagnosis or treatment by any dentist or physician licensed by the State of Oklahoma and hospital service that may be rendered to said minor under the general, specific or special consent of the:

DIOCESAN MIDDLE SCHOOL ATHLETIC ASSOCIATION (DMSAA)

The temporary custodian of the minor; whether such diagnosis or treatment is rendered at the office of the physician or dentist, or at a hospital licensed by the State of Oklahoma, I authorize the physician or dentist to call in any necessary consultant at his/her/their discretion. I further authorize said physician or dentist to exercise his/her/their discretion in authorizing proper and necessary treatment.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required, but is given to encourage those persons who having temporary custody of the minor, and said physician or dentist to exercise his/her/their best judgment as to the requirements of such diagnosis of medical or dental treatment.

This consent shall remain effective as long as my child is involved with the DMSAA unless sooner revoked in writing, delivered to said persons instructed with the custody, care and control of the minor.

I will not hold DMSAA financially responsible for the medical care and/or the transportation costs to obtain medical care.

PARENT OR GUARDIAN: AFFIRMATION OF ANNUAL REVIEW

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Hazing Policy Agreement

The Catholic Schools and the Diocese of Tulsa will take all rumors of hazing seriously and rumors will be investigated. Although ambiguity exists on the definition of "hazing", it is the goal of the DMSAA, Catholic Schools Office and the Diocese of Tulsa to clarify and educate our students and parents so that these activities are eliminated from classrooms, groups and sports teams. The following definition of hazing is found on the "StopHazing.org" website and will be adopted to help clarify all possible incidents of hazing in the Diocese of Tulsa:

> *Hazing refers to any activity expected of someone joining a group (or to maintain full status in a group) that humiliates, degrades or risks emotional harm regardless of the person's willingness to participate.*

I, _____ have read and understand the hazing policy and will report any activity that is suspicious of hazing, whether I am a bystander, or one that is being hazed.

_____
Signature

_____
Position (Coach, Parent, Athlete)

_____
Date

Pre-participation Physical Evaluation HISTORY FORM

Date of Exam:

Name	*Sex*	*Age*	*Date of Birth*
Grade	*School*		*Sport(s)*
Address		*Phone*	
Personal Physician			
In case of emergency, contact:			
Relationship	*Phone (H)*		*Phone (W)*

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

	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have an ongoing medical condition (like diabetes, asthma)?		
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicine or pills?		
4. Do you have allergies to medicines, pollens, foods, or stinging insects?		
5. Have you ever passed out or nearly passed out DURING exercise?		
6. Have you ever passed out or nearly passed out AFTER exercise?		
7. Does your heart race or skip beats during exercise?		
8. Does your heart race or skip beats during exercise?		
9. Has a doctor ever told you that you have (check all that apply): ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection		
10. Has a doctor ever ordered a test for your heart? (i.e., ECG, echocardiogram)		
11. Has anyone in your family died for no apparent reason?		
12. Does anyone in your family have a heart problem?		
13. Has any family member or relative died of heart problems or of sudden death before age 50?		
14. Does anyone in your family have Marfan syndrome?		
15. Have you ever spent the night in a hospital?		
16. Have you ever had surgery?		
17. Have you ever had an injury like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or game? If yes, circle affected area below:		
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:		
19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:		
Head / Neck / Shoulder / Upper Arm / Elbow / Forearm / Hand / Fingers / Chest Upper back / Lower back / Hip / Thigh / Knee / Calf / shin / Ankle / Foot / toes		
20. Have you ever had a stress fracture?		
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?		
22. Do you regularly use a brace or assistive device?		
23. Has a doctor ever told you that you have asthma or allergies?		
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
25. Is there anyone in your family who has asthma?		
26. Have you ever used an inhaler or taken asthma medicine?		
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?		
28. Have you had infectious mononucleosis (mono) within the last month?		
29. Do you have any rashes, pressure sores, or other skin problems?		
30. Have you had a herpes skin infection?		
31. Have you ever had a head injury or concussion?		
32. Have you been hit in the head and been confused or lost your memory?		
33. Have you ever had a seizure?		
34. Do you have headaches with exercise?		

	Yes	No
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
36. Have you ever been unable to move your arms or legs after being hit or falling?		
37. When exercising in the heat, do you have severe muscle cramps or become ill?		
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?		
39. Have you had any problems with your eyes or vision?		
40. Do you wear glasses or contact lenses?		
41. Do you wear protective eyewear, such as goggles or a face shield?		
42. Are you happy with your weight?		
43. Are you trying to gain or lose weight?		
44. Has anyone recommended you change your weight or eating habits?		
45. Do you limit or carefully control what you eat?		
46. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
47. Have you ever had a menstrual period?		
48. How old were you when you had your first menstrual period?		
49. How many periods have you had in the last 12 months?		
Explain "Yes" answers here:		

I HEREBY STATE THAT, TO THE BEST OF MY KNOWLEDGE, MY ANSWERS TO THE ABOVE QUESTIONS ARE COMPLETE AND CORRECT.

SIGNATURE OF ATHLETE:

SIGNATURE OF PARENT / GUARDIAN:

DATE:

Pre-participation Physical Evaluation

PHYSICAL EXAMINATION

Name _____ *Date of Birth* _____

Height _____ *Weight* _____ *Pulse* _____ *BP* _____

Vision: R 20 / _____ *L 20 /* _____ *Corrected: Y N* *Pupils: Equal* _____ *Unequal* _____

Medical	Normal	Abnormal Findings	Initials
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)			
Skin			
MUSCULOSKETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

Notes: _____

_____

Name of physician (print/type) _____ **Date** _____

Address _____ **Phone** _____

Signature of Physician _____,
MD or DO

Pre-participation Physical Evaluation CLEARANCE FORM

Name	*Sex*	*Age*	*Date of Birth*

☐ Cleared without restriction.

☐ Cleared with recommendations for further evaluation or treatment for: _____

_____

_____

☐ Not cleared for ☐ All sports ☐ Certain sports: _____ Reason: _____

Recommendations: _____

_____

EMERGENCY INFORMATION

Allergies _____

Other information _____

IMMUNIZATIONS (e.g., tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis; pneumococcal; meningococcal; varicella)

☐ Up to date (see attached documentation) ☐ Not up to date Specify _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO