Mount St. Joseph Academy
127 Convent Avenue
Rutland, Vermont 05701

Athletic Department
Marty McDonough
(802) 775-0151 ext. 121

Parental/Guardian Permission to Participate in Athletics and Release of Liability

NAME: ______________________________ DATE: ______________
Student

I hereby give permission for ____ to
Participate in the following sports at Mount St. Joseph Academy:

(Circle All sports interested in.)

CROSS COUNTRY	SOCCER	SNOWBOARD	SOFTBALL
CHEERLEADING	BASKETBALL	SKIING	TENNIS
FOOTBALL	ICE HOCKEY	BASEBALL	TRACK
WEIGHTLIFTING (activity)		LACROSSE	GOLF

And, as a participant, to travel under the coach's direction and authority from time of departure until return to Mount St. Joseph Academy.

NAME OF INSURANCE COMPANY: ____

POLICY NO. ______________________________ . We will assume full responsibility for this coverage for our student(s).

Parent's
Place of Work: ______________________________ Phone: ______________

______________________________ Phone: ______________
Home Address

____
Family Physician

____
Address

____
Phone

____
Parent/Guardian Signature

MEDICAL TREATMENT AUTHORIZATION . . . ABSENTEE

As the legal parent or guardian of the above named student, and in the event of an inquiry or illness which require immediate examination or treatment in the opinion of the Mount St. Joseph Academy staff, and if cannot be contacted, I authorize and direct Mount St. Joseph Academy in my behalf to have my student transported by car or ambulance to the hospital. Necessary emergency treatment may be given by any doctor on call. I understand that the school assumes no financial responsibility for medical care or ambulance.

Signed: ______________________________ Home Phone: ______________

If your student takes medication, please list: ______________________________

____

If your student is allergic to any kind of medication, please list: ______________________________

____

STATEMENT OF RELEASE OF LIABILITY

I hereby release Mount St. Joseph Academy from any and all legal liability for any injury to my son/daughter/ward while practicing for or playing in any games or scrimmages at Mount St. Joseph Academy.

Signature of Parent/Guardian: ______________________________ Date: ______________

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Mount St. Joseph Academy

127 Convent Avenue
Rutland, Vermont 05701

(802) 775-
Fax (802) 775-

STUDENT'S NAME ______________________ DATE OF BIRTH __________ GRADE ____

PARENT/GUARDIAN ______________________ PHONE # ______________

ADDRESS ____

SPORTS PARTICIPATION IN ______________________ TODAY'S DATE ________

INSTRUCTIONS FOR PARENTS & STUDENTS: Please answer the following questions before presenting this form to the physician for a sports physical.

1. Have you ever been unconscious or lost memory from a blow to the head? Yes No
2. Have you had a fracture or dislocation in the last two years? Yes No
3. Have you had a knee or ankle sprain in the last two years? Yes No
4. Have you had any other injuries:
   Describe ______________________ Yes No
5. Are you under a physician's care now?
   For what? ______________________ Yes No
6. Have you had an illness or an injury lasting more than a week in thee last 6 months? Yes No
   If yes, please explain. ______________________
7. Have you been in the hospital for an operation or to stay overnight? Yes No
8. Have you ever felt faint or fainted during exercise? Yes No
9. Has any family member suffered a heart attack before the age of 50? Yes No
10. Do you have any worries about your health or questions you would like to discuss with a Physician? Yes No

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INSTRUCTIONS TO PHYSICIANS: This student is about to enter a program of strenuous activity. A Physical Exam is required every two years. Please review the ssports questionnaire filled out by the student and parent and note the possible disqualifying conditions.

I. CONDITIONS WHICH MAY ACT AS DISQUALIFIERS:
   - A. Enlargement of spleen after mononucleosis
   - B. Bleeding disorder
   - C. Asthma – during acute episodes or exercise – induced asthma not controlled by medication
   - D. Acute or chronic strains and sprains of joints
   - E. Epilepsy if not well controlled by medication
   - F. Persistent hypertension not controlled by medication/salt restriction
   - G. Acute infection until fever free for 48 hours

II. CONDITIONS WHICH MAY DISQUALIFY STUDENTS FROM STRENUOUS SPORTS:
   - A. Physical signs suggesting mitral or aortic stenosis
   - B. Coarctiation of the aorta, prolapse of mitral valve, or post infectious carditis – need evaluation of cardiologist
   - C. Ectopic beats that ddo not disappear when pulse rate goes above 140 with exercise – need evaluation of cardiologist

III. CONDITIONS WHICH MAY DISQUALIFY STUDENT FROM CONTACT/COLLISION SPORT
   - A. Loss of paired organ – eye, kidney, testicle
   - B. Previous retinal detachment
   - C. Sever strain or sprain that has not been evaluated within three months to contact sport
   - D. Concussion – one concussion – removed from the game
     - two concussions – disqualify for season
     - three concussions – need evaluation by neurologist or neurosurgeon before participating again

(over)

PHYSICAL EXAMINATION (To be completed by Physician)

STUDENT'S NAME: ______________________________

Height: ______ Percentile: ______ Blood Pressure: ______

Weight: ______ Percentile: ______ Last Tetanus Toxoid: ______

MMR #2: ______

General: Muscular, Slender, Obese

	Normal	Abnormal (please explain)
Eyes – Vision Bilateral, glass appropriate for sport, contact lenses?	____	____
Ears – Hearing bilateral (any perforation)	____	____
Nose – Septal diviation	____	____
Mouth – Caps, loose teeth, orthodontic appliances	____	____
Neck – Range of motion, thyroid	____	____
Lungs – Aeration, abnormal sounds__	____	____
Heart – Size, rhythm, murmurs Heart rate should be monitored after predetermined stress	____	____
Abdomen – enlarged liver/spleen, masses, hernia, bruits	____	____
Genitalia – Testes – size – one or two, varococele	____	____
Spine – flexibility – scoliosis	____	____
Extremities – strength – flexibility Range of motion, joint/ligament stability Swelling – deformity, peripheral pulses	____	____
Neurological – Alert Cranial nerve function, Peripheral nerve function	____	____

Other: ______________________________

I feel this student can participate in the sport of choice providing he/she can pass the physical fitness test for that sport.

Date of Physical ______________

____
Signature of Physician

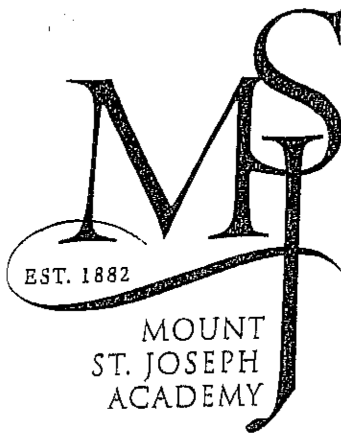
____
Print name of Physician

SECOND YEAR WAIVER

I hereby state that my student's physical condition has not changed drastically since last year's physi examination. Date of last examination: ______________

____
Date

____
Parent/Guardian Signature



127 Convent Avenue
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(802) 775-0151
(802) 775-0424 FAX
www.msjvermont.org

Date: ___________________________

Student Name____________________

We have received and read the information provided to parents and students regarding concussion. Also included and received is the Return to Play Procedure that MSJ will use.

____
Parent /Guardian Signature

____
Student Signature