All Saints Academy

1110 Four Mile Rd NE Grand Rapids MI 49525 (616) 363-7725

Both this consent and the athletic physical form must be completed and signed even if you have your physical done elsewhere. To practice or participate in the All Saints Academy Sports program, both completed forms must be in the School Office by August 1.

Consent to Participate in Sports

1. I hereby give permission for my child to engage in sports at All Saints Academy.
2. I am familiar with the common hazards of sports, and fully understand the dangers associated with them. I hereby release and discharge All Saints Academy and the sports league, its agents, employees, and officers from all liability whatsoever for personal injuries, damage to property arising out of sports activities on the premises at school, or at any other location where games or practices are conducted, or in transportation to or from contests at other locations.
3. I understand that I am responsible for all equipment/uniforms issued to my child, and I personally guarantee to return it at the close of the season, and to make restitution for any undue damage or loss of the equipment/uniforms.
4. I understand that it is my responsibility to provide medical and insurance coverage for my child in case of accidental injury. All Saints Academy, or any of its agents or coaches, will not be responsible for medical bills incurred due to injury to my child. My child is presently covered by the following medical insurance policy. Name of Company:_______________________________________ Policy Number: ___________________
5. I understand that my child will not be allowed to practice sports unless this consent form and a current valid physical is on file in the School Office.

Date: ______________________ Parent/Guardian Signature: ________________________________

Child's Name: _______________________________________ 2010-2011 Grade: ______________

Birthdate: ______________ Telephone: _________________________

Current Height: ______________ Current Weight: _____________________

2010-2011 Athletic Competition Health Screening Form

Name: ____________________ Family Physician: ____________________ Phone: ____________________

School: ____________________ Address: ____________________

Age: __________ Grade: __________

Birth Date: __________ Gender: __________

HEALTH HISTORY *Parent or Guardian* Answer Yes or No ONLY	YES	NO	Vitals	Satisfactory	Unsatisfactory	Physical Evaluation Comments	Recommend Follow Up
			Height				
Chronic/Recurrent Illness?			Weight				
Hospitalization?			BP				
Surgery Other Than Tonsils?			Hgb./Urine			UA P________ G________	
Injuries Treated by Physician?			General				
Current Medications?							
Organs Missing?							
Heat Exhaustion/Stroke?							
Dizziness, Fainting, Convulsions, and/or Headaches?							
Knocked Out?			Head				
Concussion?							
Wear Glasses or Contacts?			Eyes			Acuity R L W WO	
Hearing Defects?			ENT				
Dental Appliances (Bridge, Braces, Caps, Plate)?			Dental				
Cough/Pain?			Chest				
Problems With Blood Pressure, Heart, or Murmurs?			Heart				
Problems with Liver, Spleen, Kidney?			Abdomen				
Hernia?			Genitalia				
Recurrent Skin Disease?			Skin				
Bone/Joint Injury? Sprain/Dislocation? Injury Causing Missed Event?			Extremities Back, Neck				
Allergy to Medications? Name:			Allergy				
Tetanus Booster in Last 10 yrs?							
Allergic to Bee Stings?							

I hereby give my consent for my son/daughter to engage in physical education, intramural, and interscholastic athletics, and to accompany the team as a member on its out of town trips. I hereby authorize the team physician or his designee to administer emergency care to my daughter/son, in the event of accident or injury.

Signature of Parent or Guardian / Date

Recommendations

I certify that I have examined the above student and find him/her physically able to compete in supervised athletic activities as indicated below:

1. _______________ No limitations
2. _______________ Participation limited
3. _______________ Undecided, recommend further evaluation
4. _______________ Denial for any type of athletic participation

Comment:

Physician Signature Date