ACADEMY OF OUR LADY OF PEACE
2016-17 MEDICAL HISTORY AND RELEASE FOR PARTICIPATION

Name _____ Graduation Year_____ Date of Birth: _____

PART 1. MEDICAL HISTORY TO BE COMPLETED & SIGNED BY PARENT/GUARDIAN

Do you have now or have you ever had any of the following:

Yes	No		Explanation of "Yes" answers **REQUIRED –** please include dates
		Allergies (Food, Drug, Bees, etc.)	List: Epi-Pen: Yes No
		Asthma	Medications:
		Headaches or Migraines	
		Unconsciousness or Blackouts	
		Concussions or Head Injuries	Dates:
		Muscle Cramps	
		Sickle Cell Trait	
		Heat Illness (treated/hospital)	Dates:
		Lightheaded, Dizziness or Fainting	
		High Blood Pressure	
		Heart Murmur or Abnormal beat	
		Racing Heart or Pressure in Chest	
		Family History of Heart Disease	
		Sudden Death in Family <50yrs	
		Epilepsy or Seizures	
		Diabetes	
		Kidney or Bladder Problems	
		Stomach Conditions or Ulcer	
		Mononucleosis	Date:
		Missing Organs	
		Skin Issues (rash, sores, MRSA)	
		Hearing/Speech Disorder	
		ADHD or Learning Disability	Medications:
		Anxiety/Depression	Medications:
		Painful/Irregular Menstrual cycle	
		Contact Lenses/Glasses	
		Surgeries	Body Part/Date:
		Broken Bones/Stress Fracture	Body Part/Date:
		Joint Dislocations	Body Part/Date:
		Sport Injuries – within past year (i.e. sprains, strains, etc.)	Body Part/Date:
		Use of Brace or Assisted Device	Body Part:
		Other Disorders/Diseases (past or present) w/ physician evaluation	List/Dates:
		Current Medications	List:

To the best of my knowledge, the medical history provided is correct and complete. I know of no reason, not recorded, to restrict activity. I hereby give consent for Student's participation in physical education activity, weight room use, athletics and school related travel to various events using transportation qualifying under the Academy of Our Lady of Peace policies.

I authorize the Academy of Our Lady of Peace to secure emergency care for illness or injury sustained by Student and consent for Student to receive initial treatment by an athletic trainer, EMT, nurse, physician, or other licensed medical professional or facility for treatment deemed necessary. This permission includes emergency transport, surgery and admission to the hospital in addition to necessary medications and diagnostic testing. It is further understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required.

I agree to waive and relinquish all claims that I may have as a result of Student's participation in above activities against the Academy of Our Lady of Peace, its Board of Directors, the Sisters of St. Joseph of Carondelet, and their officers, agents, employees and coaches. I do hereby fully release, discharge, hold harmless and agree to indemnify OLP from all claims, financial responsibility and any liabilities whatsoever resulting from injuries (including death), damages and losses by Student and arising out of, connected with or in any way associated with their participation.

_____ _____ _____

Parent/Guardian Name (Print) Parent/Guardian Signature Date

ACADEMY OF OUR LADY OF PEACE
2016-17 PHYSICAL FORM

Name_____ **Expiration Date**_____

All freshmen and transfer students MUST have a *current* physical (dated after June 10, 2016) on file no later than the FIRST day of school. If the student does not have a completed physical form on file they WILL NOT be allowed to participate in Physical Education class. Any non-participation in Physical Education class may affect their grade.

****TO BE ELIGIBLE FOR ATHLETICS PARTICIPATION: THIS PHYSICAL MUST BE PERFORMED AFTER June 10th, 2016****

NAME:		SPORT (S):		
BIRTH DATE:		AGE:	GRADUATION YEAR:	
HEIGHT:		WEIGHT:		
BLOOD PRESSURE:		PULSE:		RESPIRATIONS:
VISION R	VISION L	PERL: ☐YES ☐NO		CORRECTIVE LENSES: ☐YES ☐NO

			COMMENTS:
APPEARANCE/SKIN	NORMAL_____	ABNORMAL_____	_____
EYES/EARS/NOSE/THROAT	NORMAL_____	ABNORMAL_____	_____
HEAD/NECK/LYMPHATICS	NORMAL_____	ABNORMAL_____	_____
CARDIOVASCULAR	NORMAL_____	ABNORMAL_____	_____
RESPIRATORY	NORMAL_____	ABNORMAL_____	_____
GASTROINTESTINAL	NORMAL_____	ABNORMAL_____	_____
NEUROLOGICAL	NORMAL_____	ABNORMAL_____	_____
MUSCULOSKELETAL			
NECK/BACK	NORMAL_____	ABNORMAL_____	_____
SHOULDER/ARM	NORMAL_____	ABNORMAL_____	_____
ELBOW/WRIST/HAND	NORMAL_____	ABNORMAL_____	_____
HIP/THIGH	NORMAL_____	ABNORMAL_____	_____
KNEE	NORMAL_____	ABNORMAL_____	_____
LEG/ANKLE/FOOT	NORMAL_____	ABNORMAL_____	_____

I certify that the medical history information has been reviewed and the above-named individual has been given a thorough physical examination covering the above information. The above-named individual is (CHECK ONE BELOW):

	Withheld from participation	Explain:
	Limited participation	Explain:
	Cleared for unlimited participation – No restrictions	

MEDICATION STATEMENT

It is deemed medically necessary for this student to carry medication/inhaler on his/her person.

Name of medication 1:	Dosage:
Name of medication 2:	Dosage:
Condition(s) needing medication:	
PHYSICIAN'S (MD or DO only) SIGNATURE:	**DATE:**
PRINTED NAME AND BUSINESS PHONE NUMBER/STAMP:	**MD or DO LICENSE NUMBER:**