FORT BEND BAPTIST ACADEMY

2009-2010 SCHOOL YEAR

ATHLETIC LIABILITY RELEASE AND MEDICAL CONSENT FORM

NAME OF ATHLETE _____

ATHLETIC LIABILITY RELEASE

I/We the parent(s)/guardian(s) of _____ do attest that our child is in good physical health.

I/We understand that participation in sports can result in injury. I/we hereby give my/our consent to allow my/our child to participate in FBBA athletic programs not specifically excluded by the parent or physician on the "medical history forms" included in this packet during the 2009-2010 season, and including off season training.

I/We assume all of the risks, hazards, and financial obligations incidental to the activity of the sport.

I/We hereby release, absolve, indemnify, and hold harmless Fort Bend Baptist Academy and the coaches, teachers, administrators, board members, volunteers, and participants and any other person or entity duly acting on behalf of Fort Bend Baptist Academy from any claims arising out of any injuries, of any nature, to my/our child while participating in FBBA activities.

MEDICAL CONSENT FORM

Permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, X-ray examinations and immunizations for the above named student if I, as a parent/guardian, am not present. In the event of serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If said physician is not able to communicate with me, the treatment necessary in the best interest of the above named student may be given.

In the event that an emergency arises during a practice session, every effort will be made to contact the parents/guardians as soon as possible. Permission is also granted to Fort Bend Baptist Academy to provide the needed emergency treatment to the athlete prior to his admission to the medical facilities.

Note: This liability release is valid for one calendar year from date signed below.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Phone Numbers where Parents/Guardians can be reached:

Office	_____	_____
Home	_____	_____
Cell	_____	_____
Other	_____	_____

Name of Family Physician _____ Phone Number _____

Insurance Company _____ Group/Policy Number _____

Middle School Physical Evaluation
2009-2010 School Year

Parent / Guardian: Please Complete Parts I and II

Part I:

Please Print

Name_____ Sex: M F Age_____ Date Of Birth_____
Last First (Circle)

Parents Name_____ Home Telephone_____

Address_____
Street City Zip Code

School_____ Grade_____ Sport(s)_____

In Case of Emergency Contact: Name_____ Relationship_____ Phone/Pager/Cell _____

Part II:

		Yes	*No*
1.	Have you ever been hospitalized?	☐	☐
2.	Have you ever had surgery?	☐	☐
3.	Are presently taking any medication	☐	☐
4.	Supplements or nonprescription drugs?	☐	☐
5.	Do you have any allergies such as medicine, pollen, or bee stings?	☐	☐
6.	Have you ever passed out during or after exercise?	☐	☐
7.	Have you ever been dizzy during or after exercise?	☐	☐
8.	Have you ever had chest pain during or after exercise?	☐	☐
9.	Have you ever had high blood pressure?	☐	☐
10.	Have you ever been told you have a heart murmur?	☐	☐
11.	Has any relative died suddenly before the age of 50?	☐	☐
12.	Do you have any current skin problems?	☐	☐
13.	Have you ever had a head injury?	☐	☐
14.	Have you ever been knocked out or unconscious?	☐	☐
15.	Have you ever had a seizure?	☐	☐
16.	Have you ever had a stinger, burner, or pinched nerve?	☐	☐
17.	Have you ever become ill from exercising in the heat?	☐	☐
18.	Do you cough, wheeze, or have trouble breathing?	☐	☐
19.	Do you have asthma?	☐	☐
20.	Have you had problems with your eyes or vision?	☐	☐
21.	Do you wear glasses or contacts?	☐	☐
22.	Do you use any special protective equipment?	☐	☐
23.	Have you ever had a sprain, strain, or swelling after injury?	☐	☐
24.	Have you had any injuries since your last Physical?	☐	☐
25.	Have you broken any bones or dislocated any joints?	☐	☐

If **YES** check the appropriate box below:

☐ Neck	☐ Head	☐ Shoulder
☐ Back	☐ Chest	☐ Elbow
☐ Arm	☐ Wrist	☐ Hand
☐ Hip	☐ Thigh	☐ Knee
☐ Shin / Calf	☐ Ankle	☐ Foot

26.	Have you been ill the last month?	☐	☐
27.	Have you had any other medical problems or recurring illness? Please explain:	☐	☐

_____

_____

Other: _____

Part III: To be completed by qualified medical personal only.

Height_____ Weight_____ BP_____/_____ Pulse_____ Vision: R 20/_____ L 20/_____

	Normal	*Abnormal*		*Normal*	*Abnormal*
Skin	☐	☐	Neck	☐	☐
Eyes, ears, nose, throat	☐	☐	Back	☐	☐
Heart and pulses	☐	☐	Shoulders	☐	☐
Lungs	☐	☐	Elbows	☐	☐
Abdomen	☐	☐	Hips	☐	☐
Genitalia (Men only)	☐	☐	Knees	☐	☐
Hernia	☐	☐	Ankles	☐	☐

Explanation of findings:

_____

_____

_____

This form must be signed by either a Physician, Physician Assistant, (licensed by the State Board of Physician Assistant Examiners), or a Registered Nurse (Recognized as an **Advanced Practice Nurse** by the Board of Nurse Examiners).

I certify the above student athlete as being physically able to participate in supervised athletic activity as checked below:

☐ Cleared for all sports activities.

☐ Cleared after completing evaluation / rehabilitation for:_____

☐ Not cleared for (list exceptions): _____ Reason _____

Recommendation: _____

Name of Physician (print) _____ Office Phone: _____

Signature of Physician: _____ Date: _____

Office stamp or attach receipt here:

Signature of Parent / Guardian: _____

NOTE: This physical is valid for one calendar year from date indicated.