

ARCHDIOCESE OF MIAMI

Catholic Athletic League of the Archdiocese of Miami

Consent to Play

Student: _____ School: _____

Sports for which the student plans to participate: _____

-
- 1 I/we hereby give consent for our child/ward to participate in interscholastic sports listed above.
 - 2 I/we am/are aware of the potential danger of concussion and /or head and neck injuries in athletic participation. I also have knowledge about the risks associated with heat related illness during athletic participation and have received information as to the risk of continuing to practice or play once a concussion or head injury is sustained without proper medical clearance
 - 3 I/we know of and acknowledge that my child/ward knows of the risks involved in athletic participation , understands that serious injury and even death, is possible in such participation and choose to accept any and all responsibility for his/her safety and welfare while participating in athletics. With full understanding of the risks involved I/we release and hold harmless my child's/ward's school against which it competes, the contest officials and coaches and the Archdiocese of Miami including all of its affiliated entities and agents of any legal responsibility and liability for any injury or claim resulting from such athletic participation I/we agree to take no legal action against my child/ward's school, the schools against which he competes, the contest officials, coaches and the Archdiocese of Miami because of any claim, cost, or cause of action arising in any way from athletic participation of my child/ward. I further authorize emergency medical treatment for my child/ward should the need arise for such treatment while my child is under the supervision of the school.

I/we have read this document carefully. I/we understand the contents of the document and I/we are aware that it contains a release of liability. I/we understand that the student may not practice or compete in any sport until this document is on file with the principal.

Parent/Guardian

Parent/Guardian

Date:

Note: This document must be completed and endorsed by the parents or guardian and kept on file at the school. When received, the document should be date stamped and initialed by the athletic director or the principal.



PREPARTICIPATION PHYSICAL EVALUATION (Page 1 of 4)

This medical history form should be retained by the healthcare provider and/or parent.

This form is valid for 365 calendar days from the date of exam.

EL2

Revised 2/25

MEDICAL HISTORY FORM

Student Information (to be completed by student and parent) *print legibly*

Student's Full Name: _____ Biological Sex: _____ Age: _____ Date of Birth: ____/____/____

School: _____ Grade in School: _____ Sport(s): _____

Home Address: _____ City/State: _____ Home Phone: (____) _____

Name of Parent/Guardian: _____ E-mail: _____

Person to Contact in Case of Emergency: _____ Relationship to Student: _____

Emergency Contact Cell Phone: (____) _____ Work Phone: (____) _____ Other Phone: (____) _____

Family Healthcare Provider: _____ City/State: _____ Office Phone: (____) _____

List past and current medical conditions:

Have you ever had surgery? If yes, please list all surgical procedures and dates:

Medicines and supplements (please list all current prescription medications, over-the-counter medicines, and supplements (herbal and nutritional):

Do you have any allergies? If yes, please list all of your allergies (i.e., medicines, pollens, food, insects):

Patient Health Questionnaire version 4 (PHQ-4)

Over the past two weeks, how often have you been bothered by any of the following problems? (Circle response)

	Not at all	Several days	Over half of the days	Nearly everyday
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

GENERAL QUESTIONS		Yes	No	HEART HEALTH QUESTIONS ABOUT YOU (continued)		Yes	No
1	Do you have any concerns that you would like to discuss with your provider?			8	Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography (ECHO)?		
2	Has a provider ever denied or restricted your participation in sports for any reason?			9	Do you get light-headed or feel shorter of breath than your friends during exercise?		
3	Do you have any ongoing medical issues or recent illnesses?			10	Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOU		Yes	No	HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		Yes	No
4	Have you ever passed out or nearly passed out during or after exercise?			11	Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35? (including drowning or unexplained car crash)		
5	Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			12	Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan Syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
6	Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?			13	Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		
7	Has a doctor ever told you that you have any heart problems?						

This form is not considered valid unless all sections are complete.



PREPARTICIPATION PHYSICAL EVALUATION (Page 2 of 4)

This medical history form should be retained by the healthcare provider and/or parent.

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EL2

Revised 2/25

Student's Full Name: _____ Date of Birth: ____ / ____ / ____ School: _____

BONE AND JOINT QUESTIONS		Yes	No
14	Have you ever had a stress fracture?		
15	Did you ever injure a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
16	Do you have a bone, muscle, ligament, or joint injury that currently bothers you?		

MEDICAL QUESTIONS		Yes	No
17	Do you cough, wheeze, or have difficulty breathing during or after exercise or has a provider ever diagnosed you with asthma?		
18	Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?		
19	Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
20	Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant staphylococcus aureus (MRSA)?		
21	Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
22	Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
23	Have you ever become ill while exercising in the heat?		
24	Do you or does someone in your family have sickle cell trait or disease?		
25	Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (continued)		Yes	No
26	Do you worry about your weight?		
27	Are you trying to or has anyone recommended that you gain or lose weight?		
28	Are you on a special diet or do you avoid certain types of foods or food groups?		
29	Have you ever had an eating disorder?		

Explain "Yes" answers here:

This form is not considered valid unless all sections are complete.

Participation in high school sports is not without risk. The student-athlete and parent/guardian acknowledge truthful answers to the above questions allows for a trained clinician to assess the individual student-athlete against risk factors associated with sports-related injuries and death. Florida Statute 1006.20 requires a student candidate for an interscholastic athletic team to successfully complete a preparticipation physical evaluation as the first step of injury prevention. This preparticipation physical evaluation shall be completed each year before participating in interscholastic athletic competition or engaging in any practice, tryout, workout, conditioning, or other physical activity, including activities that occur outside of the school year.

We hereby state, to the best of our knowledge, that our answers to the above questions are complete and correct. In addition to the routine physical evaluation required by Florida Statute 1006.20, and FHSAA Bylaw 9.7, we understand and acknowledge that we are hereby advised that the student should undergo a cardiovascular assessment, which may include such diagnostic tests as electrocardiogram (ECG), echocardiogram (ECHO), and/or cardio stress test. The FHSAA Sports Medicine Advisory Committee strongly recommends a medical evaluation with your healthcare provider for risk factors of sudden cardiac arrest which may include the special tests listed above.

Student-Athlete Name: _____ (printed) Student-Athlete Signature: _____ Date: ____ / ____ / ____

Parent/Guardian Name: _____ (printed) Parent/Guardian Signature: _____ Date: ____ / ____ / ____

Parent/Guardian Name: _____ (printed) Parent/Guardian Signature: _____ Date: ____ / ____ / ____



PREPARTICIPATION PHYSICAL EVALUATION (Page 3 of 4)
This medical history form should be retained by the healthcare provider and/or parent.
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EL2

Revised 2/25

PHYSICAL EXAMINATION FORM

Student's Full Name: _____ Date of Birth: ____ / ____ / ____ School: _____

HEALTHCARE PROFESSIONAL REMINDERS:

Consider additional questions on more sensitive issues.

• Do you feel stressed out or under a lot of pressure?	• Do you ever feel sad, hopeless, depressed, or anxious?
• Do you feel safe at your home or residence?	• During the past 30 days, did you use chewing tobacco, snuff, or dip?
• Do you drink alcohol or use any other drugs?	• Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
• Have you ever taken any supplements to help you gain or lose weight or improve your performance?	• Have you experienced performance changes, felt fatigued, and/or experienced times of low energy during the past year?

- ☐ Verify completion of FHSAA EL2 Medical History (pages 1 and 2), review these medical history responses as part of your assessment.
Cardiovascular history/symptom questions include Q4-Q13 of Medical History form. *(check box if complete)*

EXAMINATION

Height: _____ **Weight:** _____

BP: ____ / ____ (____ / ____) **Pulse:** _____ **Vision:** R 20/ _____ L 20/ _____ **Corrected:** Yes No

MEDICAL - healthcare professional shall initial each assessment **NORMAL** **ABNORMAL FINDINGS**

Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyl, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, Ears, Nose, and Throat • Pupils equal • Hearing		
Lymph Nodes		
Heart • Murmurs (auscultation standing, auscultation supine, and Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes Simplex Virus (HSV), lesions suggestive of Methicillin-Resistant Staphylococcus Aureus (MRSA), or tinea corporis		
Neurological		

MUSCULOSKELETAL - healthcare professional shall initial each assessment **NORMAL** **ABNORMAL FINDINGS**

Neck		
Back		
Shoulder and Arm		
Elbow and Forearm		
Wrist, Hand, and Fingers		
Hip and Thigh		
Knee		
Leg and Ankle		
Foot and Toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

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*Consider electrocardiography (ECG), echocardiography (ECHO), referral to a cardiologist for abnormal cardiac history or examination findings, or any combination thereof. The FHSAA Sports Medicine Advisory Committee strongly recommends to a student-athlete (parent), a medical evaluation with your healthcare provider for risk factors of sudden cardiac arrest which may include an electrocardiogram.

Name of Healthcare Professional (print or type): _____ Date of Exam: ____ / ____ / ____

Address: _____ Phone: (____) _____ E-mail: _____

Signature of Healthcare Professional: _____ Credentials: _____ License #: _____



PREPARTICIPATION PHYSICAL EVALUATION (Page 4 of 4)

SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL

This form is valid for 365 calendar days from the date of exam.

EL2

Revised 2/25

MEDICAL ELIGIBILITY FORM

Student Information (to be completed by student and parent) *print legibly*

Student's Full Name: _____ Biological Sex: _____ Age: _____ Date of Birth: ____/____/____

School: _____ Grade in School: _____ Sport(s): _____

Home Address: _____ City/State: _____ Home Phone: (____) _____

Name of Parent/Guardian: _____ E-mail: _____

Person to Contact in Case of Emergency: _____ Relationship to Student: _____

Emergency Contact Cell Phone: (____) _____ Work Phone: (____) _____ Other Phone: (____) _____

Family Healthcare Provider: _____ City/State: _____ Office Phone: (____) _____

SHARED EMERGENCY INFORMATION - completed at the time of assessment by practitioner and parent

☐ Check this box if there is no relevant medical history to share related to participation in competitive sports.

Provider Stamp (if required by school)

Medications: *(use additional sheet, if necessary)*

List: _____

Relevant medical history to be reviewed by athletic trainer/team physician: *(explain below, use additional sheet, if necessary)*

☐ Allergies ☐ Asthma ☐ Cardiac/Heart ☐ Concussion ☐ Diabetes ☐ Heat Illness ☐ Orthopedic ☐ Surgical History ☐ Sickle Cell Trait ☐ Other

Explain: _____

Signature of Student: _____ Date: ____/____/____ Signature of Parent/Guardian: _____ Date: ____/____/____

We hereby state, to the best of our knowledge the information recorded on this form is complete and correct. We understand and acknowledge that we are hereby advised that the student should undergo a cardiovascular assessment, which may include such diagnostic tests as electrocardiogram (ECG), echocardiogram (ECHO), and/or cardio stress test.

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction after clearance by medical specialist for: _____

(If this option is checked, additional medical follow-up and clearance prior to sports participation is required. Use EL2 Page 5 for documentation.)

☐ Medically eligible for only certain sports as listed below:

☐ Not medically eligible for any sports

Recommendations: *(use additional sheet, if necessary)*

In accordance with §1006.20(2)(c), F.S., I hereby certify that I am a practitioner licensed under Florida chapter 458, chapter 459, chapter 460, §464.012, or registered under §464.0123, and in good standing with my regulatory board and that I, or a clinician under my direct supervision, have examined the above-named student-athlete using the FHSAA EL2 Preparticipation Physical Evaluation and have provided the conclusion(s) listed above. A copy of the exam has been retained and can be accessed by the parent as requested. Any injury or other medical conditions that arise after the date of this medical clearance should be properly evaluated, diagnosed, and treated by an appropriate healthcare professional prior to participation in activities.

Name of Healthcare Professional (print or type): _____ Date of Exam: ____/____/____

Address: _____ Phone: (____) _____

Signature of Healthcare Professional: _____ Credentials: _____ License #: _____

This form is not considered valid unless all sections are complete.



PREPARTICIPATION PHYSICAL EVALUATION (Supplement)

SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL

This form is valid for 365 calendar days from the date of exam.

EL2

Revised 2/25

This form is only used, or requested, if a student-athlete has been referred for additional evaluation, prior to full medical clearance.

MEDICAL ELIGIBILITY FORM - Referred Provider Form

Student Information (to be completed by student and parent) *print legibly*

Student's Full Name: _____ Biological Sex: _____ Age: _____ Date of Birth: ____/____/____

School: _____ Grade in School: _____ Sport(s): _____

Home Address: _____ City/State: _____ Home Phone: (____) _____

Name of Parent/Guardian: _____ E-mail: _____

Person to Contact in Case of Emergency: _____ Relationship to Student: _____

Emergency Contact Cell Phone: (____) _____ Work Phone: (____) _____ Other Phone: (____) _____

Family Healthcare Provider: _____ City/State: _____ Office Phone: (____) _____

Referred for: _____ Diagnosis: _____

I hereby certify the evaluation and assessment for which this student-athlete was referred has been conducted by myself or a clinician under my direct supervision with the conclusions documented below:

- ☐ Medically eligible for all sports without restriction as of the date signed below
- ☐ Medically eligible for all sports without restriction after completion of the following treatment plan: *(use additional sheet, if necessary)*

☐ Medically eligible for only certain sports as listed below:

☐ Not medically eligible for any sports

Further Recommendations: *(use additional sheet, if necessary)*

Name of Healthcare Professional (print or type): _____ Date of Exam: ____/____/____

Address: _____ Phone: (____) _____

Signature of Healthcare Professional: _____ Credentials: _____ License #: _____

Provider Stamp *(if required by school)*

CAL Athletes' Responsibilities and Code of Conduct

ATHLETES MUST:

- Demonstrate respect for the Roman Catholic Church, its culture, traditions, and rituals.
- Remember that school work must remain the highest priority.
- Understand and abide by the rules and philosophy of the CAL, their Catholic school and the coaches
- Attend all practices and events for the duration of the season unless excused by the coaches.
- Be on time for practices and games and come prepared to play.
- Show respect at all times for the people, property and equipment involved in the CAL athletic program. This includes teammates, coaches and referees and your opponent.
- Do not argue with the officials. The head coach should be the only person talking with the officials. If you have an issue, discuss it with your coach.
- Practice good sportsmanship with the players and coaches from the opposing team. Win or lose.
- Remember to have fun. It is a game.

ACKNOWLEDGE AND AGREED TO:

Athlete's Name (Print): _____

Athlete's Signature: _____ Date: _____