

**DAMIEN HIGH SCHOOL ATHLETIC DEPARTMENT
EMERGENCY PROCEDURE CARD**

Name _____
Last First Middle Graduation Year Birth Date

Home Address _____ Home Phone (____) _____
Street Address City Zip code

For school year: _____ Sports Participating In: _____

IN CASE OF SUDDEN ILLNESS OR ACCIDENT TO THIS STUDENT

Mother/ Guardian: _____ Work Phone (____) _____ Cell Phone (____) _____
Name

Father/ Guardian: _____ Work Phone (____) _____ Cell Phone (____) _____
Name

Additional Contact Person: _____ Relationship to student _____
(Name of a local Neighbor or Relative)

Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

Family Doctor Name _____ Phone (____) _____

This student has a known health condition which may affect him in school. Yes _____ No _____ (If yes, please explain on reverse side)

If an emergency should arise which requires immediate medical attention and we as parents or guardians cannot be contacted, you are authorized to take whatever steps are needed to protect the health of this student.

Signature of Parent / Guardian Date _____

I have read the Athletic Clearance Packet of the Damien High School Athletic Department and agree to the provision contained therein. I hereby give my consent for the above named (my son or ward) to compete in sports and to travel with a representative of the school to scheduled athletic events.

Signature of Parent / Guardian Date _____

Insurance Company _____ Policy Holder _____ Policy No. _____

This student has:

1. A serious illness/ Chronic Condition (bleeder, diabetes, seizures, frequent fainting, heart conditions, HIV, Hepatitis, MRSA etc...) Please explain:

2. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? Please explain and include dates of injury.

3. Surgeries or Hospital over-night stays with their dates:

4. Allergies and is an epi-pen required:

5. Head Injury History: Please list any head injuries with their dates where concussion was suspected:

6. Do you or anyone in your family have sickle cell trait (please list the relationship to the student)

7. Asthma? Yes No If yes, please list the medications below.

8. Medications:

Name _____ Reason _____ Frequency Taken _____

Name _____ Reason _____ Frequency Taken _____

Name _____ Reason _____ Frequency Taken _____

Name _____ Reason _____ Frequency Taken _____

Name: _____ Sex: ____ Age: _____ Date of Birth: _____ Date of Examination: _____

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____ Vision: R 20/____ L 20/____ Corrected? Y or N

EXAMINATION	NORMAL	ABNORMAL FINDINGS	INITIALS
<u>Appearance:</u> * Marfan Stigmata (kyphoscoliosis, high - arched palate, pectus excavatum, arachnodactyly, arm span>height, hyperlaxity, myopia, MVP, aortic insufficiency)			
<u>Eyes / Ears / Nose / Throat:</u> * Pupils equal * Eye Tracking *Hearing			
<u>Lymph Nodes:</u>			
<u>Heart:</u> * Murmurs (auscultation standing, supine, +/-Valsalva) * Location of point of maximal impulse (PMI)			
<u>Pulses:</u> * Simultaneous femoral and radial pulses			
<u>Lungs:</u>			
<u>Abdomen:</u>			
<u>Genitourinary (males only):</u>			
<u>Skin:</u> * HSV, lesions suggestive of MRSA, tinea corporis			
<u>Neurologic:</u>			

MUSCULOSKELETAL			
Neck			
Back			
Shoulder/ arm			
Elbow/ Forearm			
Wrist/ Hand/ Fingers			
Hip / Thigh			
Knee			
Lower Leg/ Ankle			
Foot / Toes			
Functional: Duck-walk, single leg hop, sit to stand			

- Cleared for All Sports Without Restriction
- Cleared for All Sports Without Restriction with recommendations for further evaluation or treatment for _____
- Not Cleared
 - Pending Further Evaluation
 - For Any Sports
 - For Certain Sports _____
 - Reason _____

Recommendations _____

I have examined the above named student and completed the preparticipation physical examination. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (Print/ type) _____ Date: _____ Phone: _____

Signature of Physician: _____ MD or DO (Please Circle) Physician's Stamp: