Bishop Manogue Catholic High School

ATHLETIC CLEARANCE REQUIREMENTS

The items listed below are MANDATORY before your child can take part in official tryouts/practices for Bishop Manogue. Deadlines for completion are:

2018-19 SCHOOL YEAR
Football – August 1, 2018
Fall Sports other than Football – August 8, 2018
Winter Sports – November 7, 2018
Spring Sports – February 20, 2019

To be sure your athlete is cleared for athletic participation this year, please log into RMA at www.registermyathlete.com to create an account and complete the following steps:

1. ***REGISTER*** your child in RMA at www.registermyathlete.com for the specific sports they may want to play this school year. Student-athletes who aren't registered for a sport cannot be added to that roster!
   - While you only need to create an RMA account once, athletes must *register* each year/season for each sport they are interested in playing.
   - We highly recommend that you register your child for ALL the sports they may participate in this year—this will save you the trouble of logging back in to register each season. Registering for a sport in RMA does not obligate your child to participate in that sport.
2. ***ACKNOWLEDGE*** each document in RMA and ***E-SIGN*** where indicated.
3. ***GET AN ATHLETIC CLEARANCE PHYSICAL*** for your child at the health care provider of your choice, if you have not already done so. Physicals are valid for a full calendar year.
   - Have provider complete the NIAA Physical Exam Form and NIAA Form B

- ***UPLOAD*** the three required documents linked below to your RMA account OR deliver them to the front office, attn: Jackie Cavilia.
  - Parental/Guardian Consent Form
  - NIAA Physical Exam Form
  - NIAA Form B

4. View the mandatory NIAA Drug and Alcohol/Concussion session with your child.
   - This NIAA requirement can be completed online at this link.

Thanks, and please contact jackie.cavilia@bishopmanogue.org with any questions or problems!

Bishop Manogue Catholic High School

EDUCATING THROUGH FAITH, LEADERSHIP, KNOWLEDGE, AND COMPASSION℠

PARENTAL/GUARDIAN CONSENT FORM AND LIABILITY WAIVER - Pg. 1 of 2

Participant's Name: _____ Grade: _____

Birth Date: _____ Sex: ☐ Male ☐ Female

Parent/Guardian's name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mom's Cell: _____ Dad's Cell: _____

I, _____, grant permission for my child, _____,

Parent/Guardian's name **Child's name**

to participate in the following sports, clubs or other activities throughout the school year that, from time to time, require transportation to locations away from the campus of Bishop Manogue Catholic High School (the "School"); or to participate in a single event as described below.

Check All That Apply:

☐ **Sports:** _____

☐ **Clubs**: _____

☐ **Campus Ministry/Retreats:** _____

☐ **Other Activities:** _____

☐ **Single Event**

Type of event: _____

Date of event: _____

Individual in charge: _____

Destination of event: _____

Estimated time of departure and return: _____

Mode of transportation to and from event: _____

These activities will take place under the guidance and direction of school employees and/or volunteers from the School.

As parent and/or legal guardian, I remain legally responsible for any actions taken by the above named minor ("Participant").

I agree on behalf of myself, my child named herein, or our heirs, successors, and assigns, to hold harmless and defend the School, its officers, directors, employees, agents, volunteers, and representatives associated with the above referenced events or activities, and the Diocese of Reno, its employees, agents and volunteers, arising from or in connection with my child attending said events or activities or in connection with any illness or injury (including death) or cost of medical treatment in connection therewith, and I agree to compensate the School and the Diocese of Reno, their officers, directors, employees, agents, volunteers, and representatives associated with said events or activities, for reasonable attorney's fees and expenses arising in connection therewith.

Signature: _____ **Date**: _____

Revised 4-25-2013

Bishop Manogue Catholic High School

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PARENTAL/GUARDIAN CONSENT FORM AND LIABILITY WAIVER – Pg. 2 of 2

MEDICAL MATTERS

I hereby warrant that to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child, including responsibility for all hospital, emergency or doctor bills that may be incurred by my child.

Of the following statements pertaining to medical matters, check only those that are applicable.

☐ ***Emergency Medical Treatment:*** In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the above numbers, contact:

Name & relationship: Family _____ Phone:
Doctor: _____ Phone: _____
Family Health Plan: _____ Policy #: _____

☐ ***Other Medical Treatment:*** In the event it comes to the attention of the School, its officers, directors, employees, agents, volunteers, and representatives associated with the event, or the Diocese of Reno, its employees, agents and volunteers, that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called.

Medications:

☐ **My child is taking medication at present.** My child will bring all medications necessary and such medications will be well-labeled. Names of medications and concise directions for seeing that my child takes such medication, including dosage and frequency of dosage, are as follows: _____

☐ **No medication of any type**, whether prescription or non-prescription, may be administered to my child unless the situation is life threatening and emergency treatment is required.

☐ **I hereby grant permission for non-prescription medication** (such as aspirin, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.

Specific Medical Information: The School will take reasonable care to see that the following information will be held in confidence.

Allergic reaction (medications, food, plants, insects, etc.): _____
Immunizations: Date of last tetanus/diphtheria immunization: _____
Does the child have a medically prescribed diet or is he or she vegetarian/vegan? _____
Does your child have any physical limitations? _____

Is your child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, fainting or the like?

_____

Has the child recently been exposed to contagious diseases or conditions, such as mumps, measles, chicken pox, etc.? If so, date and disease or condition: _____

You should be aware of these medical conditions of my child: _____

_____

Signature: _____ **Date:** _____

Please fill out both pages. Revised 4-25-2013

FORM B -- NIAA PRE-PARTICIPATION HISTORY FORM

HISTORY DATE OF EXAM: _____

NAME: _____ SEX: _____ AGE: _____ D.O.B.: _____

GRADE: _____ SCHOOL: _____ SPORT(S):_____

ADDRESS: _____ PHONE: _____

PERSONAL PHYSICIAN: _____

IN CASE OF EMERGENCY, CONTACT - NAME: _____

RELATIONSHIP: _____ PHONE (H): _____ (W): _____

EXPLAIN "YES" ANSWERS BELOW.
CIRCLE QUESTIONS YOU DON'T KNOW THE ANSWERS TO.

		YES	***NO***
1.	Do you have a chronic medical condition (asthma, diabetes, high blood pressure, etc.)?	_____	_____
2.	Have you ever been hospitalized overnight?	_____	_____
3.	Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler?	_____	_____
4.	Do you have any allergies (for example, to pollen, medicine, food, or stinging insect)?	_____	_____
5.	a. Have you passed out or been dizzy during exercise?	_____	_____
	b. Have you had chest pain (or pressure) with exercise?	_____	_____
	c. Have you had excessive unexplained shortness of breath or fatigue with exercise?	_____	_____
	d. Is there a family history of premature death or morbidity from cardiovascular disease in a relative younger than age 50?	_____	_____
	e. Is there any history in your family of hypertropic cardiomyopathy, dilated cardiomyopathy long QT syndrome or Marfan's syndrome?	_____	_____
	f. Has a physician denied or restricted your participation in sports for any heart problem?	_____	_____
6.	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)?	_____	_____
7.	a. Have you had a head injury or concussion?	_____	_____
	b. Have you been knocked out, become unconscious, or lost your memory?	_____	_____
	c. Have you had a seizure?	_____	_____
	d. Do you have frequent or severe headaches?	_____	_____
	e. Have you had numbness or tingling in your arms, hands, legs, or feet?	_____	_____
8.	Have you become ill from exercising in the heat?	_____	_____
9.	Do you cough, wheeze, or have trouble breathing during or after activity?	_____	_____

Over >

		YES	*NO*
10.	a. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	_____	_____
	b. Are you missing an eye, kidney, testicle or ovary?	_____	_____
11.	a. Have you had any problems with your eyes or vision?	_____	_____
	b. Do you wear glasses, contacts, or protective eyewear?	_____	_____
12.	a. Have you had any problems with pain or swelling in muscles, tendons, bones, or joints?	_____	_____

b. If yes, check appropriate item and explain below.

_____ Head	_____ Elbow	_____ Hip
_____ Neck	_____ Forearm	_____ Thigh
_____ Back	_____ Wrist	_____ Knee
_____ Chest	_____ Hand	_____ Shin/Calf
_____ Shoulder	_____ Finger(s)	_____ Ankle
_____ Upper Arm	_____ Foot	_____ Toe(s)

13. Are you actively trying to gain or lose weight? _____ _____

14. Would you like to talk to someone about stress, anger, depression or other issues? _____ _____

15. Record the dates of your most recent immunizations (shots) for:

Tetanus _____ Measles _____

Hepatitis B _____ Chickenpox _____

FEMALES ONLY

16. When was your first menstrual period? _____
When was your most recent menstrual period? _____
How much time do you usually have from the start of one period to the start of another? _____
How many periods have you had in the last year? _____
What was the longest time between periods in the last year? _____

EXPLAIN "YES" ANSWERS HERE: _____

_____

_____

Name of physician (print/type): _____ Phone: _____

Address: _____

Street City State Zip Code

I, _____hereby certify that I am a licensed _____, and have reviewed the information in this FORM B prior to conducting a physical examination for the assigned student.

_____ _____

Signature of Health Practitioner License Number Office Phone Number Date

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

_____ _____ _____

Signature of Athlete Signature of Parent/Guardian Date

** Revised 5-2010; June 2012

FORM D -- Health Practitioner, please refer to the letter & references provided on Form C.
NIAA PRE-PARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION

DATE OF EXAMINATION: _____

NAME: _____ DATE OF BIRTH: _____

HEIGHT: _____ WEIGHT: _____ % BODY FAT (optional): ____ PULSE: _____ BP: _____/_____ (____/____, ____/____)

VISION: R 20/ _____ L 20/ _____ CORRECTED: Y / N PUPILS: Equal _____ Unequal_____

MEDICAL	**NORMAL /ABSENT**	**ABNORMAL FINDINGS**	**EXPLAIN**	**INITIALS**
Appearance				
Eyes/Ears/Nose/Throat				
Lymph Nodes				
Lungs				
Abdomen				
Genitalia (Males Only)				
Skin				
CARDIOVASCULAR				
Murmur that Increases From Supine to Standing				
Systolic Murmur Greater Than II/VI				
Any Diastolic Murmur				
Radial & Femoral Pulses				
MUSCULOSKELETAL				
Neck				
Back				
Shoulder / Arm				
Elbow / Forearm				
Wrist / Hand				
Hip / Thigh				
Knee				
Leg / Ankle				
Foot				
Stigmata of Marfan's Syndrome				

CLEARED after completing evaluation/rehabilitation for: _____

_____

_____

NOT CLEARED FOR: _____ **REASON:** _____

Recommendations: _____

_____

_____

Name of physician (print/type): _____ **Phone:** _____

Address: _____

Street **City** **State** **Zip Code**

I, _____hereby certify that I am a licensed _____, qualified to perform NIAA Pre-Participation Evaluations, and that on the date set forth below I performed all aspects of the NIAA Pre-Participation Evaluation on the above student. This student meets all physical examination requirements for participation in NIAA sanctioned sports.

_____ _____

Signature of Health Practitioner **License Number** **Office Phone Number** **Date**

Revised 5-2010; June 2012