

MOUNT MICHAEL FAMILY PROFILE

2009-2010

STUDENT

Student's Full Name _____ Race _____

Social Security # _____ Birth date _____ Home phone _____

2nd Student's Full Name _____ Race _____

Social Security # _____ Birth date _____

Home Address _____

City/State/Zip _____

Public School District _____

FATHER

Father's Name _____ Home phone _____

Address _____ Home E-Mail _____

(If different from student)

Name of Employer _____ Occupation _____

Business address _____ Business phone _____

Business E-Mail _____ Cell phone _____

Matching Gift Company? Yes _____ No _____

MOTHER

Mother's Name _____ Home phone _____

Address _____ Home E-Mail _____

(If different from student)

Name of Employer _____ Occupation _____

Business address _____ Business phone _____

Business E-Mail _____ Cell phone _____

Matching Gift Company? Yes _____ No _____

PARISH OR CHURCH NAME _____

ADDRESS _____

OTHER CHILDREN		
Name	Age	School/Employer

LIVING GRANDPARENTS:

Father's parents:	
Grandfather _____	Grandmother _____
Current/Former Occupation _____	
Address _____	Phone _____

Mothers' parents:	
Grandfather _____	Grandmother _____
Current/Former Occupation _____	
Address _____	Phone _____

CAREER PROGRAM

As part of *Mount Michael's Career Program*, we like to have a list of parents who are willing to provide information to students regarding their careers through "shadowing" (visiting a job site or talking to the students at a convenient time) or speaking at our *Career Night Program*.

If you would like to participate in these programs, please indicate the career topic you would like to address:

Name _____ Topic _____

Name _____ Topic _____

**4MOUNT MICHAEL BENEDICTINE SCHOOL
PERMISSION FORM**

CONCERNING TRANSPORT TO AND FROM EVENTS DURING THE SCHOOL WEEK:

Mount Michael will provide transportation under the following conditions of consent and release of liability.

As a parent and legal guardian, you remain fully responsible for any legal responsibility which may result from personal actions taken by your son.

RELEASE, DISCHARGE AND COVENANT NOT TO SUE the above named school and abbey, its representatives or assignees for any and all claims and liability arising out of strict liability or ordinary negligence of release, which causes the undersigned any injury or property damage and further agrees to hold release harmless and indemnify release from any claim, judgment or expenses release may incur by participation in the described activity.

Parent or Legal Guardian signature:

_____ Date: _____

PERMISSION FORM for Returning to Campus at the Start of the School Week

For the 2009-2010 school year, our son

(Print Name)

will return to campus:

_____ On Sunday evenings (or the evening before the resumption of classes after breaks) by 9:30 P.M.

_____ On Monday morning (or the morning of the resumption of classes) by 7:30 A.M.

_____ Is enrolled in the Day Student Program (My son's cell phone # is _____)

_____ Is enrolled in the 7 Day Boarding Program

_____ Parent or Legal Guardian Signature

_____ Date

Any deviation from the above must be cleared with my son's Dean, by me or my spouse (NOT MY SON), in advance.

**NEBRASKA SCHOOL ACTIVITIES ASSOCIATION
PERMISSION FORM
2009-2010**

School: **Mt. Michael Benedictine School, Elkhorn, NE**

Name of Student _____

Date of Birth _____ Place of Birth _____

The undersigned(s) are the Student and the parent(s), guardian(s), or person(s) in charge of the above named Student and are collectively referred to as "Parent".

The Parent and Student hereby:

- (1) Understand and agree that participation in NSAA sponsored activities is voluntary on the part of the Student and is a privilege;
- (2) Understand and agree that (a) by this Consent Form the NSAA has provided notification to the Parent and Student of the existence of potential dangers associated with athletic participation; (b) participation in any athletic activity may involve injury of some type; (c) the severity of such injury can range from minor cuts, bruises, sprains, and muscle strains to more serious injuries to the body's bones, joints, ligaments, tendons, or muscles, to catastrophic injuries to the head, neck and spinal cord, and on rare occasions, injuries so severe as to result in total disability, paralysis and death; and, (d) even with the best coaching, use of the best protective equipment, and strict observance of rules, injuries are still a possibility;
- (3) Consent and agree to participation of the Student in NSAA activities subject to all NSAA by-laws and rules interpretations for participation in NSAA sponsored activities, and the activities rules of the NSAA member school for which the Student is participating; and
- (4) Consent and agree to the Student being photographed, video taped, audio taped, or recorded by any other means while participating in NSAA activities and contests, consent to and waive any privacy rights with regard to the display of such recordings, and waive any claims of ownership or other rights with regard to such photographs or recordings or to the broadcast, sale or display of such photographs or recordings.

I acknowledge that I have read paragraphs (1) through (4) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participation in athletic activities.

DATED this _____ day of _____, _____.

SIGNATURE OF STUDENT _____

PARENT'S OR LEGAL GUARDIAN'S CONSENT

I hereby give my permission for _____ to practice and compete for the above named high school in activities approved by the Nebraska School Activities Association **except those crossed out below.**

baseball	basketball	cross-country	football	golf
wrestling	tennis	track	soccer	swimming

I have read the rules of eligibility pertaining to activities participation and acknowledge and understand the purpose and content thereof.

I also realize that participation in high school athletics involves the potential for injury which is inherent in all sports. I acknowledge that even with the best coaching, use of the most advanced protective equipment and strict observance of rules, injuries are still a possibility. On rare occasions these injuries can be so severe as to result in total disability, paralysis, or even death.

I acknowledge that I have read and understand this warning.

SIGNATURE OF PARENT OR LEGAL GUARDIAN _____

DATE OF EXAM _____

Name _____ Sex _____ Age _____ Date of birth _____
 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. Has a doctor ever denied or restricted your participation in sports for any reason?
 2. Do you have an ongoing medical condition (like diabetes or asthma)?
 3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?
 4. Do you have allergies to medicines, pollens, foods, or stinging insects?
 5. Have you ever passed out or nearly passed out DURING exercise?
 6. Have you ever passed out or nearly passed out AFTER exercise?
 7. Have you ever had discomfort, pain, or pressure in your chest during exercise?
 8. Does your heart race or skip beats during exercise?
 9. Has a doctor ever told you that you have (check all that apply):
 High blood pressure A heart murmur
 High cholesterol A heart infection
 10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)
 11. Has anyone in your family died for no apparent reason?
 12. Does anyone in your family have a heart problem?
 13. Has any family member or relative died of heart problems or of sudden death before age 50?
 14. Does anyone in your family have Marfan syndrome?
 15. Have you ever spent the night in a hospital?
 16. Have you ever had surgery?
 17. Have you ever had an injury, like a sprain, muscle or ligament tear or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below:
 18. Have you had any broken or fractured bones, or dislocated joints? If yes, circle below:
 19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:
- | | | | | | | | |
|------------|------------|----------|-----------|-------|-----------|--------------|-----------|
| Head | Neck | Shoulder | Upper arm | Elbow | Forearm | Hand/fingers | Chest |
| Upper back | Lower back | Hip | Thigh | Knee | Calf/shin | Ankle | Foot/toes |
20. Have you ever had a stress fracture?
 21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?
 22. Do you regularly use a brace or assistive device?
 23. Has a doctor ever told you that you have asthma or allergies?

- | | | |
|--|------------|-----------|
| | Yes | No |
|--|------------|-----------|
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?
 25. Is there anyone in your family who has asthma?
 26. Have you ever used an inhaler or taken asthma medicine?
 27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?
 28. Have you had infectious mononucleosis (mono) within the last month?
 29. Do you have any rashes, pressure sores, or other skin problems?
 30. Have you had a herpes skin infection?
 31. Have you ever had a head injury or concussion?
 32. Have you been hit in the head and been confused or lost your memory?
 33. Have you ever had a seizure?
 34. Do you have headaches with exercise?
 35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?
 36. Have you ever been unable to move your arms or legs after being hit or falling?
 37. When exercising in the heat, do you have severe muscle cramps or become ill?
 38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?
 39. Have you had any problems with your eyes or vision?
 40. Do you wear glasses or contact lenses?
 41. Do you wear protective eyewear, such as goggles or a face shield?
 42. Are you happy with your weight?
 43. Are you trying to gain or lose weight?
 44. Has anyone recommended you change your weight or eating habits?
 45. Do you limit or carefully control what you eat?
 46. Do you have any concerns that you would like to discuss with a doctor?
- FEMALES ONLY**
47. Have you ever had a menstrual period?
 48. How old were you when you had your first menstrual period? _____
 49. How many periods have you had in the last year? _____

Explain "Yes" answers here: _____

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 _____

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I hereby give permission for the release of the attached student medical history and the results of the actual physical examination to the school for the purposes of participation in athletics and activities.
 Parent or Legal Guardian Signature _____ Date _____

Preparticipation Physical Evaluation

PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

Height _____ Weight _____ % Body fat (optional) _____ Pulse _____ BP ____/____ (____/____, ____/____)

Vision R 20/____ L 20/____ Corrected: Y N Pupils: Equal ____ Unequal ____

Follow-Up Questions on More Sensitive Issues

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Do you feel stressed out or under a lot of pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you feel safe? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. During the past 30 days, did you use chewing tobacco, snuff, or dip? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. During the past 30 days, have you had at least 1 drink of alcohol? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever taken steroid pills or shots without a doctor's prescription? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever taken any supplements to help you gain or lose weight or improve your performance? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Questions from the Youth Risk Behavior Survey (http://www.cdc.gov/HealthyYouth/yrbs/index.htm) on guns, seatbelts, unprotected sex, domestic violence, drugs, etc | <input type="checkbox"/> | <input type="checkbox"/> |

Notes:

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary [†]			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

*Multiple-examiner set-up only.

[†]Having a third party present is recommended for the genitourinary examination.

Notes:

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

Preparticipation Physical Evaluation

CLEARANCE FORM

Name _____ Sex _____ Age _____ Date of birth _____

Cleared without restriction

Cleared, with recommendations for further evaluation or treatment for: _____

Not cleared for All sports Certain sports: _____ Reason: _____

Recommendations: _____

EMERGENCY INFORMATION

Allergies _____

Other Information _____

IMMUNIZATIONS (eg, tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis; pneumococcal; meningococcal; varicella)

Up to date (see attached documentation) Not up to date Specify _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

**MOUNT MICHAEL BENEDICTINE SCHOOL
MEDICAL/IMMUNIZATION RECORD
2009-2010**

NAME: _____ AGE: _____ GRADE: _____

PARENT(GUARDIAN) NAME: _____

EMERGENCY CONTACT: _____ PHONE: _____

IMMUNIZATION HISTORY

FOR CURRENT STUDENTS OF MT. MICHAEL:

Please list the immunizations (month/year) given during the **PAST YEAR**:

NONE: _____

DPT/TD ____/____ POLIO ____/____ MMR ____/____ VARICELLA ____/____

HEPATITIS B ____/____, ____/____, ____/____ OTHER ____/____ - _____
(Name)

FOR NEW OR TRANSFER STUDENTS TO MT. MICHAEL (must be completed in detail):

DPT Series ____/____, ____/____, ____/____, ____/____, ____/____, ____/____

POLIO Series ____/____, ____/____, ____/____, ____/____, ____/____

MMR (Measles, Mumps, Rubella) ____/____, ____/____

HEPATITIS B ____/____, ____/____, ____/____

VARICELLA (Chickenpox) ____/____, ____/____ HAD DISEASE: ____/____

OTHER: _____

MEDICAL AUTHORIZATION

I authorize the Deans of Mt. Michael Benedictine School to give my son the following over-the-counter medicine, Advil/Tylenol, Cough Drops and Dilotab (Cold & Sinus Relief).

Parent/Guardian Signature: _____

List health care providers (including specialists) and phone numbers:

Name:	Phone:
Name:	Phone