MOUNT MICHAEL FAMILY PROFILE
2024-2025

STUDENT INFORMATION

Student's Full Name _____ Race _____

Birth date _____ Cell # _____

2nd Student's Full Name _____ Race _____

Birth date _____ Cell # _____

Home Address _____

City/State/Zip _____

PUBLIC SCHOOL DISTRICT (Required) _____

FATHER

Father's Name _____ Phone (H) _____ (C) _____

Address/City/State/Zip _____
(If different from student)

Home E-mail: _____

Name of Employer _____ Occupation _____

Address/City/State/Zip _____

Business phone _____ Matching Gift Company? Yes _____ No _____

Business E-mail _____

MOTHER

Mother's Name _____ Phone (H) _____ (C) _____

Address/City/State/Zip _____
(If different from student)

Home E-mail: _____

Name of Employer _____ Occupation _____

Address/City/State/Zip _____

Business phone _____ Matching Gift Company? Yes _____ No _____

Business E-mail _____

PARISH/CHURCH NAME _____

ADDRESS _____

OTHER CHILDREN

Name	Gender	Grade	School
_____	M/F	_____	
_____	M/F	_____	
_____	M/F	_____	
_____	M/F	_____	

LIVING GRANDPARENT INFORMATION:

Father's parents:

Grandfather_____ Grandmother_____

Current/Former Occupation_____

Address_____ Phone_____

City/State/Zip _____

Mother's parents:

Grandfather_____ Grandmother_____

Current/Former Occupation_____

Address_____ Phone_____

City/State/Zip _____

Alumni Relatives of Mount Michael (if not listed above)

Name_____ Relationship to Student: _____ Grad Year _____

Email address_____

Name_____ Relationship to Student: _____ Grad Year _____

Email address_____

NSAA Athletic and Activities
Student and Parent Consent Form

School Year: 2024-2025
Member High School: Mount Michael Benedictine
Name of Student: _____
Date of Birth: _____ Place of Birth: _____
Name of Parent(s), Guardian(s), or Person(s) in Charge: _____
Relationship to Student: _____
Address(es) of Student and Parent(s)/Guardian(s)/or Person(s) in Charge**: _____

Note: If Student and all Parents/Guardians do not live in the same household, please include all addresses and inform the Member School as this may impact eligibility.

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 and understand and agree that (a) by this Consent Form the NSAA has provided notice of the existence of potential dangers associated with athletic and activity participation; (b) participation in any activity may involve injury or illness of some type, including exposure to communicable diseases, and even catastrophic injury, paralyzation, and death; and (c) even the best supervision, the use of the best protective equipment and strict observance of rules, injuries are still a possibility;

(2) Consent and agree to participation of the Student in NSAA activities subject to (a) all NSAA Bylaws and rules interpretations, including limitations on transfers and limitations on the use of the Student's name, image, and likeness when wearing school uniforms or engaging in commercial activity tied to the Student's participation in NSAA activities; and (b) the athletic and activities rules of the Member School;

(3) Consent and agree to the disclosure by the Member School to the NSAA, and subsequent disclosure by the NSAA, of information regarding the Student contained in the Member School's directory information or other similar policies, and any other records or documentation needed to determine the Student's eligibility and compliance necessary to participate in NSAA activities;

(4) Understand that (a) prior to athletic participation, a pre-participation release form signed by a health care professional must be signed and submitted to the Member School; and (b) for purposes of determining fitness to participate, injury, injury status, or emergency response, Parents may be asked to consent to the disclosure of confidential medical records or information. Records and information shared for this purpose will not be redisclosed to any entities outside of the health care provider(s), Member School, or NSAA;

(5) Consent and agree (a) to authorize licensed or trained individuals, including certified sports injury personnel, to evaluate and treat any injury or illness that occurs during the Student's participation in NSAA activities. This includes all reasonable and necessary care, treatment, and rehabilitation for these injuries that is made available by the Member school and/or the NSAA, including transportation of the Student to a medical facility if necessary; and (b) that Parents are obligated to pay for professional medical and/or related services; the NSAA and the Member School shall not be liable for payment of such services even if made available by the Member School or NSAA.

(6) Understand that the Student or Student's likeness being photographed, video recorded, audio taped, or recorded by any other means while participating in NSAA activities and contests and that any such recording may be used for broadcast, sale, or display.

We, Parent(s) and Student, acknowledge that I have read paragraphs (1) through (6) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participation in athletics and activities, and agree that Student may participate in NSAA activities.

Student Printed Name	**Student Signature**	**Date of Signature**
_____		_____
Parent(s) Printed Name(s)	**Parent Signature(s)**	**Date of Signature(s)**
_____		_____

PHYSICALS MUST BE COMPLETED AFTER MAY 1, 2024

PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

List past and current medical conditions. _____

Have you ever had surgery? If yes, list all past surgical procedures. _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

_____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

_____

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
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

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
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)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

1. 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?
   - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
   - 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?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • 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	**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		

[a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a comination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

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.

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

MEDICAL QUESTIONS	Yes	No
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. 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?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease?		
24. Have you ever had or do you have any problems with your eyes or vision?		

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

FEMALES ONLY	Yes	No
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "Yes" answers here.

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

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

_____

_____

☐ Medically eligible for certain sports

_____

_____

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: _____

_____

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are 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 medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: _____

_____

_____

Medications: _____

_____

_____

Other information: _____

_____

_____

Emergency contacts: _____

_____

_____

MOUNT MICHAEL BENEDICTINE SCHOOL
MEDICAL/IMMUNIZATION RECORD
2024-2025

NAME: _____ AGE: _____ GRADE: _____

PARENT/GUARDIAN NAME: _____

EMERGENCY CONTACT: _____ PHONE: _____

DOES YOUR SON HAVE ANY KNOWN ALLERGIES: NO____ YES____ LIST: _____

INSURANCE CO NAME (Required): _____ **POLICY NO:** _____

MEDICAL AUTHORIZATION

I do☐ or do not ☐ authorize Mount Michael Benedictine School to give my son the following over-the-counter medicine, Advil/Tylenol, Cough Drops, Sinus and Cold Relief, Allergy Relief, and Antacid.

Parent/Guardian Signature: _____

IMMUNIZATION HISTORY

FOR CURRENT STUDENTS OF MOUNT MICHAEL:

Please list the immunizations (month/day/year) given during the PAST YEAR ONLY or attach shot record from doctor's office:

NONE: _____

DPT/TD: _____ POLIO: _____ MMR: _____ VARICELLA: _____

HEPATITIS B: _____, _____, _____ HEPATITIS A: _____, _____

COVID-19: _____, _____, _____ OTHER: _____ _____, _____

FOR NEW OR TRANSFER STUDENTS TO MOUNT MICHAEL (list month/day/year or attach shot record from doctor's office):

DPT Series: _____, _____, _____, _____, _____, _____

POLIO Series: _____, _____, _____, _____, _____

MMR (Measles, Mumps, Rubella): _____, _____

HEPATITIS B: _____, _____, _____

HEPATITIS A: _____, _____

VARICELLA (Chickenpox) **(2 doses are required)**: _____, _____ HAD DISEASE: _____

TDaP: _____ TD: _____ COVID-19: _____, _____, _____

OTHER: _____ _____, _____

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

Name:	Phone:
Name:	Phone

MOUNT MICHAEL BENEDICTINE SCHOOL
PERMISSION FORM
2024-2025

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 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 2024-2025 school year, our son

_____ Cell #: _____
(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.

_____is enrolled in the 7 Day Boarding Program.

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

_____ _____
Parent or Legal Guardian Signature Date

STUDENT HANDBOOK ACKNOWLEDGEMENT FORM

We draw your attention to the vaccination policy in the school handbook.

Mount Michael Vaccination Policy

To ensure the health of both Mount Michael students and the larger community, vaccinations **are required** of all students, and parents or guardians are required to provide evidence of their son's vaccination history. No personal exemptions to this policy will be accepted. The only exception to this policy will be a detailed medical exemption that is provided by a medical doctor. Any medical exemption must use a form that Mount Michael will provide upon request, and it must be submitted directly to the school office by the medical doctor. Any waiver that may have been accepted by a student's previous school will not automatically be accepted by Mount Michael.

The following vaccinations **ARE REQUIRED** for all students, based on the Nebraska Department of Health and Human Services regulations:

- Diphtheria, Tetanus, Pertussis (DPT) – 3 doses of DTaP, DTP, DT or Td vaccine, one given on or after the 4th birthday.
- Tdap (with pertussis booster) required in 7th grade.
- Polio – 3 doses of polio vaccine.
- Measles/Mumps/Rubella (MMR) – 2 doses of MMR or MMRV vaccine, given on or after 12 months of age and separated by at least one month.
- Hepatitis B – 3 doses of pediatric Hep B or 2 doses of adolescent vaccine if student is 11-15 years of age.
- Varicella (chicken pox) – 2 doses given on or after 12 months of age. If the child has had varicella disease, they do not need the vaccination.

By signing this form, I am acknowledging that my son and I have read the Student Handbook which is available online and will read the 2024-2025 Student Handbook when it becomes available early summer.

Son's Signature: _____ **Date:** _____

Parent's Signature: _____ **Date:** _____

HEALTH CARE POWER OF ATTORNEY

(THIS FORM MUST BE COMPLETED & NOTARIZED FOR ALL NEW SEVEN DAY BOARDERS)

I, _____, of _____, _____,
(Name of Parent/Guardian) (City) (State/Country)

is the parent/guardian of _____, a minor child. I hereby designate
(Name of Minor Child)

any Mount Michael Benedictine School representative to act as attorney-in-fact to make healthcare decisions on behalf of the minor child named above, including the power to consent to surgical operations, and other medical and dental treatment.

This delegation is made for a period of four years from the execution of this Power of Attorney.

This Power of Attorney shall not be affected by disability of the undersigned and shall remain in effect to the extent permitted by law, notwithstanding later disability or inability of the undersigned, or a later uncertainty as to whether the undersigned may be dead or alive.

DATED: _____

_____
(Signature of Parent/Guardian)

_____
(Printed Name of Parent/Guardian)

STATE OF _____)
) SS
COUNTY OF _____)

Before me, a Notary Public qualified in and for said County, personally came _____, known to me to be the identical person who signed the foregoing instrument and he acknowledged the execution thereof to be his voluntary act and deed.

WITNESS my hand and Notarial Seal on _____.

_____
Notary Public