



BISHOP CONNOLLY HIGH SCHOOL

373 Elsbree Street
Fall River, MA 02720
tel 508.676.1071
fax 508.676.8594

ATHLETIC PERMISSION & MEDICAL FORM 2018 – 2019

COMPLETE BOTH SIDES: PLEASE PRINT

DATE _____

Student-Athlete Information

SPORT(S) _____				L.E.A.P.	FR	SO	JR	SR
				CLASS YEAR				
FIRST NAME _____	LAST NAME _____			M	F	GENDER		
MAILING ADDRESS _____				CITY _____	STATE _____	ZIP _____		
TELEPHONE _____	PARENT EMAIL _____			DATE OF BIRTH _____				

Medical History

YES	NO	
<input type="radio"/>	<input type="radio"/>	Are you currently being treated for any health condition? If yes, explain: _____
<input type="radio"/>	<input type="radio"/>	Do you have any chronic or recurrent type of injury that needs protection or support? If yes, explain: _____
<input type="radio"/>	<input type="radio"/>	Have you had any joint injuries or fractures in the last two years? If yes, list injuries and dates: _____
<input type="radio"/>	<input type="radio"/>	Have you had surgery for an illness or injury within the last two years? If yes, describe: _____
<input type="radio"/>	<input type="radio"/>	Do you have any blood disorders? If yes, explain: _____
<input type="radio"/>	<input type="radio"/>	Do you have any eating disorders? If yes, explain: _____
<input type="radio"/>	<input type="radio"/>	Have you ever been treated for heat exhaustion or dehydration? If yes, list condition(s) and date(s): _____
<input type="radio"/>	<input type="radio"/>	Have you had a major illness in the past twelve months? i.e, mononucleosis, pneumonia, meningitis, etc. If yes, explain: _____
<input type="radio"/>	<input type="radio"/>	Have you ever passed out during or after exercise? If yes, when: _____
<input type="radio"/>	<input type="radio"/>	Have you ever been dizzy during or after exercise? If yes, when: _____
<input type="radio"/>	<input type="radio"/>	Have you ever experienced chest pain during or after exercise? If yes, when: _____
<input type="radio"/>	<input type="radio"/>	Have you ever been told you have a heart murmur? If yes, when: _____
<input type="radio"/>	<input type="radio"/>	Has any relative died of heart problems or suffered sudden death before the age of 50? If yes, please explain: _____
<input type="radio"/>	<input type="radio"/>	Are you missing any paired organs? i.e., eyes, lungs, kidneys, testicles, etc. If yes, list: _____
<input type="radio"/>	<input type="radio"/>	Has a physician ever denied or restricted your participation in sports for any health reasons? If yes, explain: _____
		What was the date of your last tetanus shot? _____



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CONCUSSION REPORTING FORM

(Must be completed every sports season)

_____	_____	_____	L.E.A.P.	FR	SO	JR	SR
FIRST NAME	LAST NAME	DATE OF BIRTH		CLASS YEAR			
_____				M	F		
SPORT				GENDER			

Concussion Policy

In compliance with Massachusetts Concussion Law (Chapter 166 of Acts of 2010), student-athletes and their parents, coaches, athletic directors/trainers, school nurses, and physicians must learn about consequences of head injuries and concussions through training programs and written materials. **The law requires that athletes and their parents inform the school about prior head injuries at the beginning of the season.** Subsequently, the Bishop Connolly Athletics Department requires the following mandates from student-athletes and their parent/guardian concerning head injury and concussion.

1. All student-athletes and their parent/guardian must read the concussion policy in the Student/Parent Handbook.
2. Student-athlete and parent/guardian are to sign this form, authorizing they have accurately reported history of concussion or head-related injury concerning the student-athlete.
3. Student-athlete and parent/guardian will attend the yearly concussion education meeting before the start of the school year.

Concussion History

Have you ever sustained a head, face or neck injury/concussion? (Circle one)	YES	NO
Was this injury diagnosed by a physician? (Circle one)	YES	NO
If yes, please explain each occurrence and list the date of the injury.	Date	

_____	_____
_____	_____
_____	_____

Parent/Guardian Concussion Statement

By authorizing this form, I have become aware of concussion laws and understand information concerning sports-related head injury and concussion.

I agree to report any head, face, or neck injury sustained by my child immediately to the school athletic trainer and/or the athletic director.

In addition, I am aware of my responsibility in accurately reporting concussion history and am aware of my overall responsibility in the role of concussion management.

_____	_____
PARENT/GUARDIAN SIGNATURE	DATE

_____	_____
STUDENT SIGNATURE	DATE