# ACADEMY OF OUR LADY OF PEACE

## 2025-2026 MEDICAL RELEASE FOR PARTICIPATION

| Student's First Name: | | Student's Last Name: | | Grad Year: | | Date of Birth: | |
|---|---|---|---|---|---|---|---|

**Please circle which OLPActivity your daughter plans on joining:**

**Physical Education Class - Tennis Golf Volleyball Cross Country Sideline Cheer Competitive Cheer Competitive Dance Equestrian Surf Soccer Basketball Water Polo Archery Lacrosse Track & Field Softball Swim & Dive Sand Volleyball Flag Football**

**PART 1. MEDICAL HISTORY TO BE COMPLETED BY PARENT/GUARDIAN**

Do you have now or have you ever had any of the following:

| Yes | No | | Explanation of "Yes" answers **REQUIRED –** please include dates |
|---|---|---|---|
| | | Allergies (Food, Drug, Bees, etc.) | List: Epi-Pen: Yes No |
| | | Asthma | Medications: |
| | | Headaches or Migraines | |
| | | Unconsciousness or Blackouts | |
| | | Concussions or Head Injuries | Dates: |
| | | Muscle Cramps | |
| | | Sickle Cell Trait | |
| | | Heat Illness (treated/hospital) | Dates: |
| | | Lightheaded, Dizziness or Fainting | |
| | | High Blood Pressure | |
| | | Heart Murmur or Abnormal beat | |
| | | Racing Heart or Pressure in Chest | |
| | | Family History of Heart Disease | |
| | | Sudden Death in Family <50yrs | |
| | | Epilepsy or Seizures | |
| | | Diabetes | |
| | | Kidney or Bladder Problems | |
| | | Stomach Conditions or Ulcer | |
| | | Mononucleosis | Date: |
| | | Missing Organs | |
| | | Skin Issues (rash, sores, MRSA) | |
| | | Hearing/Speech Disorder | |
| | | ADHD or Learning Disability | Medications: |
| | | Anxiety/Depression | Medications: |
| | | Painful/Irregular Menstrual cycle | |
| | | Contact Lenses/Glasses | |
| | | Surgeries | Body Part/Date: |
| | | Broken Bones/Stress Fracture | Body Part/Date: |
| | | Joint Dislocations | Body Part/Date: |
| | | Sport Injuries – within past year (i.e. sprains, strains, etc.) | Body Part/Date: |
| | | Use of Brace or Assisted Device | Body Part: |
| | | Other Disorders/Diseases (past or present) w/ physician evaluation | List/Dates: |
| | | Current Medications | List: |

To the best of my knowledge, the medical history provided is correct and complete. I know of no reason, not recorded, to restrict activity. I hereby give consent for Student's participation in physical education activity, weight room use, athletics and school related travel to various events using transportation qualifying under the Academy of Our Lady of Peace policies.

I authorize the Academy of Our Lady of Peace to secure emergency care for illness or injury sustained by Student and consent for Student to receive initial treatment by an athletic trainer, EMT, nurse, physician, or other licensed medical professional or facility for treatment deemed necessary. This permission includes emergency transport, surgery and admission to the hospital in addition to necessary medications and diagnostic testing. It is further understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required.

I agree to waive and relinquish all claims that I may have as a result of Student's participation in above activities against the Academy of Our Lady of Peace, its Board of Directors, the Sisters of St. Joseph of Carondelet, and their officers, agents, employees and coaches. I do hereby fully release, discharge, hold harmless and agree to indemnify OLP from all claims, financial responsibility and any liabilities whatsoever resulting from injuries (including death), damages and losses by Student and arising out of, connected with or in any way associated with their participation.

Parent/Guardian Name (Print) _____ Parent/Guardian Signature _____ Date _____

**Academy of Our Lady of Peace Physical Form 2025-2026**

**Name:**_____
**Exp. Date:**_____

**All freshmen and transfer students MUST have a *current* physical (dated June 1, 2025 or LATER) on file no later than the FIRST day of school. If the student does not have a completed physical form on file they WILL NOT BE ALLOWED to participate in Physical Education class. Non---participation in Physical Education class may affect their grade.**

****TO BE ELIGIBLE FOR ATHLETICS PARTICIPATION: THIS PHYSICAL MUST BE PERFORMED June 1, 2025 OR LATER AND UPLOADED TO DOCUMENT-LOK IN YOUR POWERSCHOOL ACCOUNT NO LATER THAN JULY 25, 2025****

| | | | |
|---|---|---|---|
| NAME: | | SPORT (S): | |
| BIRTH DATE: | | AGE: | GRADUATION YEAR: |
| HEIGHT: | | WEIGHT: | |
| BLOOD PRESSURE: | | PULSE: | RESPIRATIONS: |
| VISION R | VISION L | PERL: ☐YES ☐NO | CORRECTIVE LENSES: ☐YES ☐NO |

| | | | COMMENTS: |
|---|---|---|---|
| APPEARANCE/SKIN | NORMAL_____ | ABNORMAL_____ | _____ |
| EYES/EARS/NOSE/THROAT | NORMAL_____ | ABNORMAL_____ | _____ |
| HEAD/NECK/LYMPHATICS | NORMAL_____ | ABNORMAL_____ | _____ |
| CARDIOVASCULAR | NORMAL_____ | ABNORMAL_____ | _____ |
| RESPIRATORY | NORMAL_____ | ABNORMAL_____ | _____ |
| GASTROINTESTINAL | NORMAL_____ | ABNORMAL_____ | _____ |
| NEUROLOGICAL | NORMAL_____ | ABNORMAL_____ | _____ |
| MUSCULOSKELETAL | | | |
| NECK/BACK | NORMAL_____ | ABNORMAL_____ | _____ |
| SHOULDER/ARM | NORMAL_____ | ABNORMAL_____ | _____ |
| ELBOW/WRIST/HAND | NORMAL_____ | ABNORMAL_____ | _____ |
| HIP/THIGH | NORMAL_____ | ABNORMAL_____ | _____ |
| KNEE | NORMAL_____ | ABNORMAL_____ | _____ |
| LEG/ANKLE/FOOT | NORMAL_____ | ABNORMAL_____ | _____ |

**I certify that the medical history information has been reviewed and the above-named individual has been given a thorough physical examination covering the above information. The above-named individual is (CHECK ONE BELOW):**

| | | |
|---|---|---|
| | Withheld from participation | Explain: |
| | Limited participation | Explain: |
| | Cleared for unlimited participation – No restrictions | |

**MEDICATION STATEMENT**

It is deemed medically necessary for this student to carry medication/inhaler on his/her person.

| | |
|---|---|
| Name of medication 1: | Dosage: |
| Name of medication 2: | Dosage: |
| Condition(s) needing medication: | |
| **PHYSICIAN'S SIGNATURE:** | **DATE:** |
| **PRINTED NAME AND BUSINESS PHONE NUMBER/STAMP** | **CALIFORNIA LICENSE NUMBER** |