YOUTH & YOUNG ADULT MINISTRY AND CYO OFFICE – CYO ATHLETIC PREPARTICIPATION FORM

(PLEASE TYPE OR PRINT)

STUDENT'S NAME _____ **BIRTH DATE**_____ **SEX** ____ **GRADE** _____
LAST FIRST

ADDRESS_____ **SCHOOL** _____
STREET CITY ZIP

PARISH _____ **PARISH CITY** _____

PARENT/GUARDIAN(S) NAME _____ **EMAIL** _____

MOBILE/WORK TELEPHONE NO. _____**HOME TELEPHONE NO.**_____

Carefully complete the following questions before your physical exam. Explain "YES" answers below.	**YES**	**NO**
1. Has this athlete ever had hospitalization, surgery, injury, serious medical or psychological illness?	___	___
2. Is this athlete now under the care of a physician or taking any medication?	___	___
3. Has any physician ever recommended or do you feel that there should be limits placed on participation in competitive sports by this student?	___	___
4. Does this athlete have any known allergies? (medication, pollen, food, stinging insects)	___	___
5. Does this athlete wear glasses or contact lenses? Give date of last eye exam if "YES"	___	___
6. Has this athlete ever blacked out, been knocked out, lost consciousness or been dizzy during or after physical activity?	___	___
7. Has this athlete ever had racing of the heart, skipped heart beat or heart murmur?	___	___
8. Has this athlete ever had a head injury or concussion?	___	___
9. Has this athlete ever had a seizure?	___	___
10. Does this athlete use special protective/corrective equipment that isn't usually used? (For example knee brace, ankle brace, foot orthotics, hearing aid, etc.)	___	___
11. Does this athlete lose weight regularly to meet weight requirements for the sport?	___	___

Explain any YES answers: _____

I/we, the undersigned consent to the participation of the above-named child in CYO athletics including practice sessions, scrimmages and athletic contests. In consideration of participation in these programs, and wishing to promote and benefit this non-profit cause, I/we, the undersigned participant/parent, on behalf of myself, my heirs, legatees, and assigns, hereby agree to indemnify, save, and hold harmless the Catholic Charities Health & Human Services, Inc.(CCHHS), the Bishop of the Roman Catholic Diocese of Cleveland , the Roman Catholic Diocese of Cleveland, sponsoring Catholic Parishes/Schools and any of their agents, representatives, employees, successors or assigns for my health, safety or any injury and/or disability arising out of or resulting from: (CHECK all programs that apply)

___CROSS COUNTRY ___FOOTBALL ___VOLLEYBALL ___SOCCER ___CHEERLEADING

___BASKETBALL ___WRESTLING ___BASEBALL ___SOFTBALL ___TRACK & FIELD

As a participant/parent in the program, I/we recognize and acknowledge that there are certain risks or physical injury and I/we agree to assume the full risk of any injuries, including loss of life, damages or loss which I/we may sustain as a result of participating in any and all activities connected with or associated with such program. The undersigned acknowledge that the participant has prepared for the sport in which participating by adequately conditioning and practicing. I/we hereby represent that I have no physical restrictions that would prohibit my participation in the sport that I have selected. The Youth & Young Adult Ministry and CYO Office has my permission to have a physician attend me if deemed necessary during my participation in this CYO program.

I/We also give permission and authorize CCHS, it agents, employees, successors and assigns to photograph or otherwise electronically or digitally record my image, or that of my child for which I am guardian participating in these athletic programs for the publication in printed or electronic form to be seen and disseminated to the general public in any media including CCHHS newsletter, poster, display, film, video or website.

I/we further agree to waive and relinquish all claims, fully release and discharge and agree to indemnify and hold harmless and defend the CCHHS, Youth & Young Adult Ministry and CYO Office and its officers, agents, servants and employees from any and all claims resulting from injuries, including loss of life, damages and losses sustained by me and arising out of, connected with, or in any way associated with activities of the program.

Participants Signature _____ **Date** _____

Parent or Guardian Signature _____ **Date** _____

Parent or Guardian Signature _____ **Date** _____

This athlete has family medical insurance: ____ YES ____ NO If yes, the Child is covered by:

INSURANCE COMPANY: _____ **POLICY NO.** _____ **EFFECTIVE DATE:** _____

HISTORY AND CONSENT MUST BE COMPLETED PRIOR TO PHYSICAL EXAM

STUDENT'S HEIGHT _____ **WEIGHT** _____ **BP** _____ **PULSE** _____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Muscular skeletal			

OPTIONAL TESTS
URINALYSIS
ALBUMIN _____
SUGAR _____
MICRO (IF ABOVE TEST ABNORMAL)
_____
BLOOD COUNT
(FOR FEMALES)
HGB. _____
OR
HCT. _____

***Station-based examination only.**

SHOULD THERE BE ANY LIMITATIONS PLACED ON ATHLETIC PARTICIPATION? YES ___ NO___

RECOMMENDATIONS: _____

_____

_____

PHYSICIAN'S NAME, ADDRESS & PHONE (STAMP OR PRINT)

I certify that I have on this date examined this student and that, on the basis of the examination requested by the CYO authorities and the student's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities. (NOTE EXCEPTIONS IN RECOMMENDATIONS AREA)

PHYSICIAN'S SIGNATURE_____

PHYSICIAN'S TELEPHONE NO. _____**DATE**_____

EMERGENCY MEDICAL AUTHORIZATION

Student Name _____

Address _____

Telephone _____

NAME: Last _____ First _____ BIRTHDATE: _____

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

PART I OR II MUST BE COMPLETED
PART I TO GRANT CONSENT

In the event reasonable attempts to contact me at _____(phone number) or _____(other parent or guardian) at _____ (phone number) have been unsuccessful, I hereby give my consent or: (1) the administration of any treatment deemed necessary by Dr. _____(physician & phone number) or Dr. _____ (dentist & phone number), or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to _____(hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted: _____

_____

_____

_____

_____ _____

Date Signature of Parent or Guardian

_____

Address

DO NOT COMPLETE PART II IFYOU COMPLETED PART I
PART II REFUSAL TO CONSENT

I do not give my consent for emergency medical treatment of my child, in the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to:

_____

_____

_____

_____ _____

Date Signature of Parent or Guardian

_____

Address