Diocese of Youngstown

ELEMENTARY ATHLETIC PARTICIPATION / EMERGENCY MEDICAL FORM

DIOCESE PARISH or SCHOOL

SPORTS PROGRAM

NAME OF STUDENT

DATE OF BIRTH | SEX | AGE | GRADE | T-SHIRT SIZE

STUDENT'S ADDRESS

CITY | STATE | ZIP

PARENT/GUARDIAN 1

PARENT/GUARDIAN 2

PARENT/GUARDIAN 1 PHONE NUMBER ☐Emergency Contact

PARENT/GUARDIAN 2 PHONE NUMBER ☐Emergency Contact

PARENT/GUARDIAN 1 ADDRESS ☐Same as Student

PARENT/GUARDIAN 2 ☐Same as Student

I, the parent/guardian of the above-named player, a minor, agree that I and the player will abide by the rules and regulations set forth by my parish/school athletic department in consideration of the player's participation in the inter-school/intramural athletic programs. I, for myself, and the player, and our respective heirs, administrators, and successors intending to be legally bound, hereby release, discharge and/or indemnify the parties including the parish/school listed above, the owners and operators of the facilities used for the programs, and their respective directors, officers, employees, agents, and representatives from and against all claims, liabilities, damages, or causes of action arising out of or in connection with the player's participation in the programs including, without limitation, player's transportation to and from any program, which transportation is hereby authorized. I further attest that I have my own health and injury insurance. Further, I understand that the Diocese of Youngstown Student/Athletic Accident Program is secondary and not meant to replace or supplement my own insurances.

I hereby request that the above-named student be permitted to participate in inter-school/intramural athletic program for the _____ school year. I hereby assume all responsibility in the event of accident or injury. I also understand that the school, parish, and coaches cannot be held liable for any injuries received while participating in the inter-school/intramural athletic program. NO student will be permitted to participate in athletic programs without confirmation of medical insurance. *

*PLEASE NOTE THAT BY SIGNING THE FORM BELOW, YOU CERTIFY THAT THE STUDENT IS COVERED BY YOUR OWN HEALTH INSURANCE WHICH COVERS ATHLETIC INJURIES OR HAVE PURCHASED A SPECIAL INSURANCE PLAN THAT COVERS THE SAME.

NAME OF MEDICAL INSURANCE COMPANY

POLICY/GROUP NUMBER

PARENT/GUARDIAN 1 SIGNATURE

PARENT/GUARDIAN 1 PRINTED NAME

DATE

PARENT/GUARDIAN 2 SIGNATURE

PARENT/GUARDIAN 2 PRINTED NAME

DATE

SPORTS PHYSICAL WAIVER *(box must be checked before student is eligible for participation)*

☐ I hereby affirm that a physician has 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 is on record in the physician's 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).

EMERGENCY MEDICAL INFORMATION

Are there any allergies, medical problems, or medication of which the SCAD and/or medical personnel should be informed?

☐YES ☐NO

If YES, please explain on back of form.

☐ I hereby give my consent permitting personnel/coaches to apply First Aid treatment until the family doctor can be contacted.

☐ I hereby give my consent to the SCAD personnel/coaches to secure ambulance service and transfer the player to _____ (preferred hospital) or any reasonably accessible hospital.

A copy of this form will be kept on hand with coaching staff

Allergies, medical problems, or medication of which the SCAD and/or medical personnel should be informed:

_____

_____

_____

_____

_____

_____

_____

_____

REGISTRATION FEES

AMOUNT PAID: $_____

☐CASH ☐CHECK (NUMBER): _____ RECEIVED BY: _____