



## **5 Steps for Spring Sports Registration at St. Francis of Assisi**

These steps must be completed before the first day of practice, March 5, 2012 or your child will be unable to practice with the team. Please print this entire document, complete and return.

**NOTE: IF YOU PARTICIPATED IN A FALL and/or WINTER 2011 SPORT THROUGH ST. FRANCIS OF ASSISI, YOU WILL ONLY NEED TO PAY THE PAY TO PLAY FEE IN STEP 1. YOU SHOULD HAVE ALSO COMPLETED STEPS 2, 3 AND 4 AND CAN GO DIRECTLY TO STEP 5.**

**Step1) Three checks made out to St. Francis of Assisi Boosters, or cash equivalent will need to be turned in with the COMPLETED paperwork.**

**Check #1: Pay to Play Fee**

Track and Field (grades 4-8) \$85

Intramural Track and Field (grade 1- 3) \$75

Baseball (grades 4-8) \$85

Fast Pitch (grades 4-8) \$85

Fees Paid after February 11, 2012 will require an added \$50 late fee.

**Check #2: St. Francis Family Booster Membership Fee**

\$25

This fee will only be collected ONE Time per Year per FAMILY

Note: Check #1 and Check #2 can be combined into one check.

**Check #3: Uniform Deposit**

\$100

The uniform deposit will be collected ONE time per ATHLETE for the year. This check will not be cashed. At the completion of the athletic year, when your athlete's uniform(s) are returned, the check will be destroyed unless otherwise specified. The check will be cashed in the event that the uniform is not returned

**Step2) Medical form 100% complete (Preparticipation Examination Form)**

Your child should receive a physical using the form below

\*All signatures on this form must be signed

**Step3) Emergency Medical Authorization form 100% complete.**

Use the form below

\* All signatures on this form must be signed

**Step4) Authorization to Photograph form complete (OPTIONAL)**

We cannot post your child's picture on the website without this form below

**Step5) Deliver/Mail all forms and the check or cash to:**

Eileen Klear, St Francis Athletic Director

6850 Mayfield Road

Gates Mills, OH 44040

**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, its 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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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 \_\_\_\_\_

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

**EMERGENCY MEDICAL AUTHORIZATION**

\_\_\_\_\_  
Student Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone

NAME: \_\_\_\_\_  
Last

First

**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 IF YOU 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

BIRTHDATE: \_\_\_\_\_



## *Catholic Charities Health and Human Services*

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### **AUTHORIZATION TO PHOTOGRAPH & RELEASE**

I, \_\_\_\_\_, residing at \_\_\_\_\_,  
(Name of Party to be Photographed) (Address)

hereby give permission and authorize Catholic Charities Health & Human Services (hereinafter "CCHHS"), its agents, employees, successors and assigns to photograph, or otherwise electronically or digitally record my image (or the image of the minor child for whom I am parent or legal guardian) for publication in printed or electronic form, and for my image (or that of my minor child) to be seen and disseminated to the general public in any media form, including, but not limited to a CCHHS newsletter, poster, display, film, video or website.

In consideration of my participation in a CCHHS program, and wishing to promote and benefit this non-profit cause, I hereby release and hold harmless CCHHS, any of its related corporate entities, the Bishop of the Roman Catholic Diocese of Cleveland, the Roman Catholic Diocese of Cleveland, their representatives, licensees, agents, employees, successors and assigns, from any and all liability for claims and demands arising out of the use of my image in any aforementioned media. I specifically waive any rights and claims that I may have or claim for privacy, invasion of privacy, libel, payment or royalties for use of the above-described photograph, as well as any other claims for damages or other relief in law or equity.

I have read and fully understand the contents of this Authorization to Photograph and Release, and agree to the provisions contained herein.

**IN WITNESS WHEREOF**, I set my hands hereto as of the date set forth below:

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Name of Party Photographed or  
Parent/Legal Guardian of Party Photographed

\_\_\_\_\_  
Date

Rev 2/15/2006