



2017 Spring CYO Sports Registration Form

Athlete Information

First Name	Last Name
School	Parish
Grade	Date of Birth
Address	City
Home Phone	Zip

Parent Information

Mother First Name	Father First Name
Mother Last Name	Father Last Name
Mother Email	Father Email
Mother Cell	Father Cell

CYO Softball - 3rd thru 8th (girls)

- Slow-pitch for Grades 3-5, Fastpitch for grades 6-8
- Register by March 6th - \$85.00

CYO Track - 3rd thru 8th (boys and girls)

- Register by March 6th - \$80.00

Rugrats Track - k thru 2nd (boys and girls)

- Register by March 6th - \$45.00

Lacrosse

- CYO now offers a lacrosse program. For this initial season, the program will be run directly through CYO, and registration is through the CYO offices. For additional information, visit <http://ccdocle.org/program/lacrosse-2>

Make checks payable to St. Mary Booster Ministry

*Registration fees are non-refundable and must accompany this registration form for the athlete to be added to a roster.

Completed Physical and Emergency Medical Authorization (EMA) forms must be included with your registration.

For your convenience, both forms are included below.

* If a current physical form has already been submitted within the last 12 months for the above athlete, please initial here _____.

Please return registration, copy of completed physical (retain original for your records), EMA, and fees no later than March 6, 2017 to:

Gary Rowan, Athletic Director
c/o St Mary School or PSR Office
401 North Street
Chardon, Ohio 44024

*NOTE: Registrations can be mailed, or dropped off at the school or parish office.

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

(PLEASE TYPE OR PRINT)

STUDENT'S NAME _____ **BIRTH DATE** _____ **SEX** _____ **GRADE** _____

ADDRESS _____ **LAST** _____ **FIRST** _____ **SCHOOL** _____

STREET _____ **CITY** _____ **ZIP** _____ **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			

*Station-based examination only.

SHOULD THERE BE ANY LIMITATIONS PLACED ON ATHLETIC PARTICIPATION? YES NO

RECOMMENDATIONS: _____

OPTIONAL TESTS

URINALYSIS _____

ALBUMIN _____

SUGAR _____

MICRO (IF ABOVE TEST ABNORMAL) _____

BLOOD COUNT

(FOR FEMALES)

HGB. _____

OR

HCT. _____

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 _____

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 _____