St Catherine's MONTESSORI

SUMMER CAMP SPORTS REGISTRATION FORM
2023

Summer soccer and volleyball camps are available to Upper Elementary through High School students (4th-12th grade). Each camp is divided into two parts: Week 1 and Week 2, and is open to both boys and girls. To participate, all necessary forms must be completed and submitted prior to the start of the camp. Please note that the camps run for specific weeks, so be sure to choose the weeks that work best for you and your child.

Soccer Summer Camp • 9:00-11:30 AM

☐ Week 1: June 5-9 • $150

☐ Week 2: July 17-21 • $150

Deadline: June 1, 2023

Volleyball Summer Camp • 9:00-11:30 AM

☐ Week 1: June 12-16 • $150

☐ Week 2: July 24-28 • $150

Deadline: June 1, 2023

• Sports fee payments will be processed through FACTS.

STUDENT INFORMATION

Student Last Name _____ First Name _____ Middle Initial _____

Nickname (if applicable) _____ Sex: ☐ Male ☐ Female Age _____

DOB (mm/dd/yy) _____ Grade _____ Classroom _____

Home Address _____ City/State/Zip Code _____

PARENT CONTACT INFORMATION

PRIMARY CONTACT (Relationship: _____)

Full Name _____ Email Address _____

Cell Number _____ Alternate Number _____

ALTERNATE CONTACT (Relationship: _____)

Full Name _____ Email Address _____

Cell Number _____ Alternate Number _____

☐ **YES –** Add me to the group email list for sport's information, updates, etc...

☐ **YES –** You may share my contact information with other team parents.

PARENTAL CONSENT FOR STUDENT PARTICIPATION:

I, _____, grant permission for my child, _____, to participate in extracurricular athletic activities. These activities will take place under the guidance and direction of school employees and/or volunteers. As a parent and/or legal guardian, I remain legally responsible fro personal actions taken by the above named minor ("student"). I agree on behalf of myself, my child named herein, our heirs, successors and assigns, to hold harmless and defend St. Catherine's Montessori, its employees, officers, directors, and agents, and the Archdiocese of Galveston-Houston, or representatives associated with these activities, arising from or in connection with my child participating in these activities, or in connection with any illness, injury or cost of medical treatment in connection therewith, and I agree to compensate St. Catherine's Montessori, its officers, directors, and agents, and the Archdiocese of Galveston-Houston, or representatives associated with the activity for reasonable attorney's fees and expenses arising in connection therewith. I hereby warrant to the best of my knowledge, that my child is in good health, and I assume all responsibility for the health and medical care of my child. In the event of a medical emergency, I hereby give permission to school employees and/or volunteers supervising the athletic event to obtain medical services and to transport my child to the nearest hospital/emergency care center for emergency medical or surgical treatment.

_____ _____ _____

Parent/Guardian Signature | Relationship | Date

EMERGENCY INFORMATION

Emergency contact if the primary or alternate contact listed above cannot be reached

Full Name _____ Phone Number _____ Relationship _____

Insurance Provider _____ Policy No. _____ Group No. _____

Name of Insured _____

Physician's Name _____ Phone Number _____

Dentist's Name _____ Phone Number _____

MEDICAL INFORMATION

Allergies _____ Medical Allergies _____

Medical Conditions _____

Medications _____

There is one (1) medical form that needs to be completed in order for your child to participate in the After-School Sports Program: The Pre-Participation Physical Evaluation (enclosed here). It is valid for 12 months.

If you already completed and returned this form earlier this summer as part of the Required Forms process, you do not need to submit it again.

St Catherine's MONTESSORI

PRE-PARTICIPATION PHYSICAL EVALUATION

2022-2023 SCHOOL YEAR

To be completed by the Parent:

STUDENT NAME: _____ DOB: _____ AGE: _____ GENDER: _____

HOME ADDRESS: _____

SCHOOL: St. Catherine's Montessori GRADE: _____ SPORT(s): _____

FATHER/GUARDIAN NAME: _____

EMAIL: _____

CELL PHONE: _____

FATHER'S EMPLOYER: _____

WORK PHONE: _____

MOTHER/GUARDIAN NAME: _____

EMAIL: _____

CELL PHONE: _____

MOTHER'S EMPLOYER: _____

WORK PHONE: _____

EMERGENCY CONTACTS

NAME: _____	NAME: _____
PHONE: _____	PHONE: _____
EMAIL: _____	EMAIL: _____
RELATIONSHIP: _____	RELATIONSHIP: _____

PHYSICIAN NAME: _____ PHONE: _____

INSURANCE PROVIDER: _____ POLICY NUMBER: _____

NAME OF INSURED: _____ GROUP NUMBER: _____

MEDICINES: List all prescription, over the counter, and supplements student is currently taking: _____

_____

Parental Consent

I grant permission for my child to participate in extracurricular athletic activities. These activities will take place under the guidance and direction of school employees and/or volunteers. As a parent and/or legal guardian, I remain legally responsible for personal actions taken by my participating child I agree on behalf of myself, my participating child, our heirs, successors and assigns, to hold harmless and defend the school, its employees, officers, directors and agents, and the Archdiocese of Galveston-Houston, or representatives associated with these activities, arising from our in connection with my child participating in these activities, or in connection with any illness, injury or cost of medical treatment in connection therewith, and I agree to compensate the school, its officers, directors and agents, and the Archdiocese of Galveston-Houston, or representatives associated with the activity for reasonable attorney's fees or expenses arising in connection therewith. I hereby warrant to the best of my knowledge, that my child is in good health, and I assume all responsibility for the health and medical care of my child. In the event of a medical emergency, I hereby give permission to school employees and/or volunteers supervising the athletic event to obtain medical services and to transport my child to the nearest hospital/emergency care center for emergency medical or surgical treatment.

Parent/Guardian Signature: _____ Date: _____

To be completed by the Physician/Licensed Examiner

STUDENT NAME: _____ DATE OF BIRTH: _____ AGE: _____

EXAMINATION

Height:_____ Weight: _____ Pulse:_____ Blood Pressure: _____/_____

Vision R 20/_____L 20/_____ Corrected: Yes☐ No☐ Pupils: Equal ☐ Unequal ☐

Hearing: Normal☐ Referred☐ Spinal Exam: Normal☐Referred☐ % Body Fat (optional)_____

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance	☐	
Eyes/ears/nose/throat	☐	
Lymph nodes	☐	
Heart-Auscultation of the heart in the **supine** position	☐	
Heart-Auscultation of the heart in the **standing** position	☐	
Heart-lower extremity pulses	☐	
Pulses	☐	
Lungs	☐	
Abdomen	☐	
Genitalia (males only)	☐	
Skin	☐	
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck	☐	
Back	☐	
Shoulder/arm	☐	
Elbow/forearm	☐	
Wrist/hand/fingers	☐	
Hip/thigh	☐	
Knee	☐	
Leg/ankle	☐	
Foot/toes	☐	

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner, will not be accepted.

CLEARANCE

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for:

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sport
- ☐ For certain sports:

Reason: _____

Recommendations: _____

Physician/Clinician Signature: _____

Print Name: _____

Address:_____

Phone: _____ **Date of Exam**: _____

To be completed by the Parent for Healthcare Provider:

DIRECTIONS: Complete questions below and explain "YES" answers in the space provided.

GENERAL QUESTIONS	**YES**	**NO**	**UNSURE**
1. Has your doctor ever denied or restricted your participation in sports for any reason?	☐	☐	☐
2. Do you have any ongoing medical conditions? If so check all that apply: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections ☐ Other:_____	☐	☐	☐
3. Have you ever spent the night in the hospital in the past year?	☐	☐	☐
4. Have you ever had surgery?	☐	☐	☐
HEART HEALTH QUESTIONS	**YES**	**NO**	**UNSURE**
5. Have you ever passed out or nearly passed out during or after exercise?	☐	☐	☐
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	☐	☐	☐
7. Does your heart ever race or skip beats (irregular beats) during exercise?	☐	☐	☐
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ High cholesterol ☐ Kawasaki disease ☐ A heart murmur ☐ A heart infection ☐ Other: _____	☐	☐	☐
9. Do you get lightheaded or feel more short of breath than expected during exercise?	☐	☐	☐
10. Have you ever had an unexplained seizure?	☐	☐	☐
11. Do you get more tired or short of breath more quickly than your friends during exercise?	☐	☐	☐
FAMILY HEART HEALTH QUESTIONS	**YES**	**NO**	**UNSURE**
12. Has any family member or relative died of heart problems or unexpected sudden death before age 50?	☐	☐	☐
13. Has any family member been diagnosed with a heart condition?	☐	☐	☐
BONE AND JOINT QUESTIONS	**YES**	**NO**	**UNSURE**
14. Have you had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or game?	☐	☐	☐
15. Have you had any fractured bones or dislocated joints?	☐	☐	☐
16. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast?	☐	☐	☐
17. Do you regularly use a brace, orthotics or other assistive device?	☐	☐	☐
18. Do any of your joints become painful, swollen, feel warm or look red?	☐	☐	☐
MEDICAL QUESTIONS	**YES**	**NO**	**UNSURE**
19. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐	☐
20. Do you have any allergies? If so, check all that apply: ☐ Pollen ☐ Medicine ☐ Food ☐ Stinging Insects ☐ Other: _____	☐	☐	☐
21. Are you missing any paired organs?	☐	☐	☐
22. Have you had a severe viral infection (myocarditis, mononucleosis, etc.) in the past year?	☐	☐	☐
23. Do you currently have any skin problems (itching, acne, warts, fungus, or blisters)?	☐	☐	☐
24. Have you ever had a head injury or concussion?	☐	☐	☐
25. Have you ever been knocked unconscious or lost memory?	☐	☐	☐
26. Do you have a history of seizure disorder?	☐	☐	☐
27. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐	☐
28. Have you ever become ill while exercising in the heat?	☐	☐	☐
29. Have you been diagnosed with or treated for Sickle Cell Trait or Sickle Cell Disease?	☐	☐	☐
30. Have you had any problems with your eyes or vision?	☐	☐	☐
31. Have you ever had unexpected shortness of breath with exercise?	☐	☐	☐
32. Have you had any eye injuries?	☐	☐	☐
33. Do you use any special protective or corrective equipment?	☐	☐	☐
34. Do you lose weight regularly to meet weight requirements for an extra-curricular activity?	☐	☐	☐
35. Are you on a special diet or do you avoid certain foods?	☐	☐	☐
36. Have you ever had an eating disorder?	☐	☐	☐
37. Are you presently under a doctor's care?	☐	☐	☐
38. Do you have any concerns you would like to discuss with a doctor?	☐	☐	☐
FEMALES ONLY			
39. What year was your first menstrual cycle?			
40. What month and day was your most recent menstrual cycle?			
41. How many cycles have you had in the last 12 months?			
COVID-19 MEDICAL QUESTIONS			
42. Have you been diagnosed with COVID-19 at any time?			
43. Have you been hospitalized at any time due to COVID-19?			