Corpus Christi School Athletic Medical Participation Form

Athletes are to see that this sheet is completed and returned to the Athletic Director
(Please print everything in pen) You cannot participate until this sheet is complete

PARENT'S E-MAIL ADDRESS: _____

Informed Consent: I realize that there is a risk of being injured that is inherent in all sports. I realize that the risk of injury may be severe, including the risk of fracture, brain injuries, paralysis, or even death.

Student's Name: _____ Sport: Basketball and/or Soccer
(As it appears on school records) (Please circle)

School Year: ***2016-2017*** Grade: _____ Date of Birth: _____ Insurance: Yes or No

School attended last year: _____

1) Parent/Guardian Name: _____ Phone: _____

Parent/Guardian Address: _____

Town, State Zip _____Cell Phone: _____

2) Parent/Guardian Name: _____ Phone: _____

Parent/Guardian Address: _____

Town, State Zip _____Cell Phone: _____

Emergency Number(s) – Family members / Friends / Neighbors

Name	Relation	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Doctor: _____ Phone: _____

Having read the informed consent and knowing the risk, (child name)_____ has my permission to participate in the school sports program. In case of injury/illness and I cannot be reached, the coach , athletic director, and/or the coaching staff has my permission to make arrangements for my son/daughter to be taken to the nearest medical / dental facility for an emergency. I hereby give my consent that a doctor of medicine or dentistry may provide my son/daughter with medical assistance and/or treatment and agree to be responsible financially for reasonable cost of such assistance and/or treatment.

My son/daughter has the following health problems and takes the following medication for a health problem. Include allergies:

_____

_____

PRACTICES AND GAMES ARE ORGANIZED BY COACHES AND VOLUNTEERS, AND SCHOOL PERSONNEL MAY OR MAY NOT BE PRESENT DURING BOTH OR EITHER. THEY DO NOT HAVE ACCESS TO MEDICATIONS. ANY PARENT OF A CHILD WITH MEDICAL CONCERNS SHOULD MAKE ARRAGEMENTS TO BE PRESENT AT PRACTICES AND GAMES.

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Insurance Information

Medical and/or Hospital Insurance Company: _____

Phone: _____ Address: _____

Policy Holder: _____ Policy # : _____

Parent/Guardian Employer: _____

Athletic Waiver and Release of Liability

In consideration of being allowed to participate in any way in the Corpus Christi School (the "School") or Church (the "Church") athletic/sports programs, and related events and activities, and in utilizing the Church or School facilities, the undersigned:

1. Acknowledges and fully understands that he/she will be engaging in activities that involve risk of serious injury, including permanent disability and death, and severe social and economic losses which might result not only from their own actions, inaction or negligence of others, the rules of play or the condition of the premises or any equipment used. Further, that there may be other risks not known to us or not reasonably foreseeable at this time.
2. Assumes all the foregoing risks and accepts personal responsibility for the damages following such injury, permanent disability or death.
3. Releases, waives, discharges and covenants not to sue the Church or School, its affiliated organizations, other participants, sponsoring agencies, sponsors, their employees and associated personnel, all of which are hereinafter referred to as "releases" from demands, losses or damages on account of injury, including death or damage of property, caused or alleged to be caused in whole or in part by the negligence of the releasees or otherwise.

THE UNDERSIGNED HAS READ THE ABOVE WAIVER, AND RELEASE, UNDERSTANDS THAT HE/SHE HAS GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT AND SIGN IT VOLUNTARILY.

_____ _____

Signature of Participant Date

_____ _____

Signature of Parent/Guardian Date

PHYSICIAN

I here by certify that _____ is physically able to participate in

( ) All sports, including collision or contact sports

OR

( ) Other (Please specify) _____

This certificate is good for the school year ***2015-2016*** unless voided by any serious injury or accident/illness. If void, it will be the responsibility of the student to get updated medical information from his/her physician before resuming participation in competitive sports.

_____/_____ _____

SIGNATURE OF PHYSCIAN DATE DATE OF LAST PHYSICAL EXAM

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