ST. RAPHAEL SPORTS REGISTRATION FORM

SPORT:

Player Name: **Grade:** **Gender** **Birth Date**

Height **Weight** **Position** For Football indicate both Offensive and Defensive Positions

Address: **City/Zip:**

Home Parish **School**

PSR? Yes No PSR Teacher's Name:

Parent Names	Home Phone	Work Phone	Cell Phone	Email

Uniform Size	Small	Medium	Large	XL

REGISTRATION FEE OF $______WAS PAID ON _________________ Cash________Check No.__________

I, the undersigned, parent of _________________________do hereby consent to permit my child to engage in the sport of __________ for the current season. Further, I, as parent and natural guardian of my minor child, and on his/her behalf, agree that neither the manager, the coach, the parish, the pastor or the Bishop of Cleveland shall be in any way legally responsible for the cost of any treatment or hospitalization or any medical expenses arising out of any injury received by my child while engaged in practice sessions or scheduled games. I further agree to save hold harmless, and indemnify, any manager, coach, parish, pastor or Bishop of Cleveland from any and all claims for damages sustained by my child arising out of his/her participation in this sport. I further agree that my child will have an annual physical examination from a physician before the child participates in any athletic activity. Per CYO League Rules, I understand that my child must attend a parochial school or be currently attending a PSR class at Saint Raphael.

PARENT SIGNATURE:____ DATE:_________________

UNIFORM AGREEMENT

Please follow these guidelines for Uniforms:

1. Wash in cold water and hang to dry
2. If uniform is lost or damaged in any way, parents will reimburse St. Raphael Athletic Commission

I understand my responsibilities in accepting the uniform and will return it within two weeks of the end of the season in excellent condition.

Player Signature ____ DATE:_________________

Parent Signature DATE:

EMERGENCY MEDICAL AUTHORIZATION

____
Student Name / Birth Date

____
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 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 for: (1) the administration of any treatment deemed necessary by Dr. _________________________ (preferred physician) or Dr. __________________________ (Preferred Dentist, or, in the event the designated practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to ________________________________(preferred hospital) or any hospital reasonably accessible.

The 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