DIOCESAN ATHLETIC INTERSCHOLASTIC PROGRAM REGISTRATION FORM

PHYSICIAN'S CERTIFICATE

I hereby certify that _____ (ATHLETE) has been examined by me and found physically fit to engage in all Diocesan interscholastic athletics for the school year 2016-2017.

PHYSICIAN'S SIGNATURE_____DATE_____

GENERAL INFORMATION

NAME OF ATHLETE _____SEX: M_____ F_____

ADDRESS _____PHONE _____

GRADE _____ AGE _____ DATE OF BIRTH _____

PARENT(S)/LEGAL GUARDIAN(S) _____

ADDRESS_____PHONE_____ CELL PHONE_____

ANOTHER PERSON TO CONTACT_____

RELATIONSHIP _____PHONE _____

ALLERGIES AND OTHER MEDICAL CONCERNS _____

_____

_____

MEDICAL INSURANCE

NAME OF INSURANCE COMPANY _____

POLICY NUMBER _____ GROUP NUMBER _____

ELIGIBILITY – RELIGIOUS EDUCATION STUDENTS

This student is an active member of _____ (NAME OF PARISH) Religious Education Program. He/she will be participating all year in the Religious Education Program.

_____ _____

(Signature of pastor or designee) (Date)

CONCUSSION STATEMENT

Initials

Student Parent

_____ _____ A concussion is a brain injury which should be reported to my parents, my coaches or a medical professional if one is available.

_____ _____ A concussion cannot be "seen". Some symptoms might be present right away. Other symptoms can show up hours or days after an injury.

_____ _N/A_ I will tell my parents, my coach and/or a medical professional about my injuries and illnesses.

_____ _N/A_ I will not return to play6 in a game or practice if a hit to my head or body causes any concussion-related symptoms.

_____ _____ I will/my child will need written permission from a ***health care provider**** to return to play or practice after a concussion.

_____ _____ Most concussions take days or weeks to get better. A more serious concussion can last for months or longer.

_____ _____ After a bump, blow, or jolt to the head or body, an athlete should receive immediate attention if there are any danger signs, such as loss of consciousness, repeated vomiting, or a headache that gets worse.

_____ _____ After a concussion, the brain needs time to heal. I understand that I am/my child is much more likely to have another concussion or more serious brain injury if return to play or practice occurs before the concussion symptoms go away.

_____ _____ Sometimes repeat concussions can cause serious and long-lasting problems and even death.

_____ _____ I have read the concussion symptoms on the "Concussion Information Sheet" found on the DAC website at www.nashvilledac.com

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**Health Care Provider* means a Tennessee licensed medical doctor, osteopathic physician or a clinical neuropsychologist with concussion training.

PARENT CONSENT STATEMENT

By signing this form, I _____ _____ (PARENT/GUARDIAN) certify that I request and give my permission for _____ (CHILD) to engage in the Diocesan interscholastic athletic program. I release the participating schools, principals, coaches, Knights of Columbus, the Diocese of Nashville and their representatives from any and all liability and waive claims against them. In addition, I have read and agree to the concussion statement above.

_____ _____

(Signature of Student/Athlete (Date)

_____ _____

(Signature of parent or legal guardian) (Date)