

# ARCHDIOCESE OF CHICAGO

## Child/Minor Athletic Participation Release Form

Child/Minor Name: \_\_\_\_\_

Address: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

## Important Information

The Catholic Bishop of Chicago (the CBC) and Mary, Undoer of Knots Parish (the Parish) are committed to conducting its athletic programs and activities in the safest manner possible and holds the safety of participants in the highest possible regard. Participants and parents registering their child in athletic programs must recognize however, that there is an inherent risk of injury when choosing to participate in athletic activities. The CBC and the Parish continually strive to reduce such risks and insist that all participants follow safe rules and instructions which have been designed to protect the participant's safety.

Please recognize that the CBC and the Parish do not carry medial accident insurance for injuries sustained in its programs. The cost of such would make program fees prohibitive. Therefore, each person registering themselves or a family member for a recreation program/activity should review their own health insurance policy for coverage. It must be noted that the absence of health insurance coverage does not make the CBC or the Parish automatically responsible for the payment of medical expenses.

Due to the difficulty and high cost of obtaining liability insurance, the agency providing liability coverage for the CBC and the Parish requires the execution of the following Waiver and Release. Your cooperation is greatly appreciated.

## Waiver and Release of ALL Claims

Please read this form carefully and be aware in registering your minor child/ward for participation in this program, you will be waiving and releasing all claims for injuries you or your minor child/ward might sustain arising out of this program.

Program: St. Robert Bellarmine Sports Program  
Program Dates: July 1, 2022 through June 30, 2023

As the parent/guardian of the participant in the program, I recognize and acknowledge that there are certain risks of physical injury and I agree to assume the full risk of injuries, (including death), damages, or loss which I or my minor child/ward may sustain as a result or participating in any and all activities connected with or associated with such program.

I agree to waive and relinquish all claims I or my minor child/ward may have, as a result of participating in the program, against the CBC, the parish and their agents, servants and employees.

I do hereby fully release and discharge the CBC and the parish and their officers, agents, servants, and employees from any and all claim from injuries, (including death), damage or loss which I or my minor child/ward may have or which may accrue to me or my minor child/ward on account of participant in the program.

I further agree to indemnify and hold harmless and defend the CBC, the parish and their officers, agents, servants, and employees from any and all claim from injuries, (including death), damages and losses sustained by me or my minor child/ward or arising out of connected with, or in any way associated with the activities of the program.

In the event of any emergency, I authorize the CBC or parish officials to secure from any licensed hospital, physician, and/or medical personnel any treatment deemed necessary for my minor child's immediate care and agree that I will be responsible for payment of any and all medical services rendered.

*I have read and fully understand the above Program Details, Waiver and Release of All Claims and Permission to Secure Treatment.*

\_\_\_\_\_  
(Parent/Guardian Signature)

\_\_\_\_\_  
(Date)

# St. Robert Bellarmine / St. Constance Sports Participation Form

## Participant Information

_____ Student Name	_____ Date of Birth	_____ Gender	_____ Grade
_____ Street Address	_____ City	_____ State	_____ Zip

## Contact Information

### Primary Contact

_____ Name	_____ Relationship to Participant	_____ Phone	_____ Email
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### Secondary Contact

_____ Name	_____ Relationship to Participant	_____ Phone	_____ Email
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## Medical Information

List participant's special needs, conditions, allergies, medications, etc.

The Sports Association will not store or administer any medications. If your child has a medical condition, a parent or guardian must be present at practices and games.

## Agreement to Participate

I have received, read and understand the Program Handbook and agree to abide by the policies stated therein. I understand that this form will be due the first day of practice or my child will not be enrolled. I have read and agreed to all the information contained in the above Parental Agreement and have filled out emergency information on my child/(ren).

\_\_\_\_\_  
Initials

I hereby grant permission to Saint Robert Bellarmine for the use of any and all photos in which I or my child/(ren) may appear (Wards of the State excluded). The usage is inclusive of, but not limited to, the publication or inclusion in brochures, posters, catalogs, handbooks, banners, and broadcast or print advertisements. I agree to waive any claim to compensation for use of said photos.

\_\_\_\_\_  
Initials

I understand that the attendee program data will be managed in a Saint Robert Bellarmine database and consent to its collection.

Are your children permitted to walk home unescorted at the time of dismissal from practices and home games?

\_\_\_\_\_  
Initials

Is anyone prohibited from picking up your children?

\_\_\_\_\_  
Yes or No

# Concussion Information Sheet

A concussion is a brain injury and all brain injuries are serious. They are caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly. In other words, even a “ding” or a bump on the head can be serious. You can’t see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

## Symptoms may include one or more of the following:

- |  |  |
|--|--|
| <ul style="list-style-type: none"><li>● Headaches</li><li>● “Pressure in head”</li><li>● Nausea or vomiting</li><li>● Neck pain</li><li>● Balance problems or dizziness</li><li>● Blurred, double, or fuzzy vision</li><li>● Sensitivity to light or noise</li><li>● Feeling sluggish or slowed down</li><li>● Feeling foggy or groggy</li><li>● Drowsiness</li><li>● Change in sleep patterns</li></ul> | <ul style="list-style-type: none"><li>● Amnesia</li><li>● “Don’t feel right”</li><li>● Fatigue or low energy</li><li>● Sadness</li><li>● Nervousness or anxiety</li><li>● Irritability</li><li>● More emotional</li><li>● Confusion</li><li>● Concentration or memory problems (forgetting game plays)</li><li>● Repeating the same question/comment</li></ul> |
|--|--|

## Signs observed by teammates, parents and coaches include:

- Appears dazed
- Vacant facial expression
- Confused about assignment
- Forgets plays
- Is unsure of game, score, or opponent
- Moves clumsily or displays in coordination
- Answers questions slowly
- Slurred speech
- Shows behavior or personality changes
- Can’t recall events prior to hit
- Can’t recall events after hit
- Seizures or convulsions
- Any change in typical behavior or personality
- Loses consciousness

Adapted from the CDC and the 3rd International Conference on Concussion in Sport Document created 7/1/2011,  
Reviewed 4/24/2013, 7/2015, 7/2017, 6/2018

# Concussion Information Sheet

## What can happen if my child keeps on playing with a concussion or returns too soon?

Athletes with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one. This can lead to prolonged recovery, or even to severe brain swelling (second impact syndrome) with devastating and even fatal consequences. It is well known that adolescent or teenage athletes will often fail to report symptoms of injuries. Concussions are no different. As a result, education of administrators, coaches, parents and students is the key to student-athlete's safety.

## If you think your child has suffered a concussion

Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear, without medical clearance. Close observation of the athlete should continue for several hours. The Return-to Play Policy of the IESA and IHSA requires athletes to provide their school with written clearance from either a physician licensed to practice medicine in all its branches or a certified athletic trainer working in conjunction with a physician licensed to practice medicine in all its branches prior to returning to play or practice following a concussion or after being removed from an interscholastic contest due to a possible head injury or concussion and not cleared to return to that same contest. In accordance with state law, all schools are required to follow this policy.

You should also inform your child's coach if you think that your child may have a concussion. Remember it's better to miss one game than miss the whole season. And when in doubt, the athlete sits out.

For current and up-to-date information on concussions you can go to: <http://www.cdc.gov/ConcussionInYouthSports/>

## Student/Parent Consent and Acknowledgements

By signing this form, we acknowledge we have been provided information regarding concussions.

### Student

Student Name (Print): \_\_\_\_\_

Grade: \_\_\_\_\_

Student Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### Parent or Legal Guardian

Name (Print): \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship to Student: \_\_\_\_\_

Each year IESA member schools are required to keep a signed Acknowledgement and Consent form and a current Pre-participation Physical Examination on file for all student athletes.

Adapted from the CDC and the 3rd International Conference on Concussion in Sport Document created 7/1/2011,  
Reviewed 4/24/2013, 7/2015, 7/2017, 6/2018



**■ PREPARTICIPATION PHYSICAL EVALUATION**

**MEDICAL ELIGIBILITY FORM**

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

- Medically eligible for all sports without restriction
- Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of \_\_\_\_\_  
\_\_\_\_\_

- Medically eligible for certain sports  
\_\_\_\_\_  
\_\_\_\_\_

- Not medically eligible pending further evaluation

- Not medically eligible for any sports

Recommendations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of health care professional: \_\_\_\_\_, MD, DO, NP, or PA

**SHARED EMERGENCY INFORMATION**

Allergies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Emergency contacts: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## ■ PREPARTICIPATION PHYSICAL EVALUATION

### HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Date of examination: \_\_\_\_\_ Sport(s): \_\_\_\_\_

Sex assigned at birth (F, M, or intersex): \_\_\_\_\_ How do you identify your gender? (F, M, or other): \_\_\_\_\_

List past and current medical conditions. \_\_\_\_\_

\_\_\_\_\_

Have you ever had surgery? If yes, list all past surgical procedures. \_\_\_\_\_

\_\_\_\_\_

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

\_\_\_\_\_

\_\_\_\_\_

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

\_\_\_\_\_

\_\_\_\_\_

Patient Health Questionnaire Version 4 (PHQ-4)  
*Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)*

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of  $\geq 3$  is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)		
	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU		
	Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)		
	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		
	Yes	No
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

BONE AND JOINT QUESTIONS		Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?			
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?			
MEDICAL QUESTIONS		Yes	No
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?			
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?			
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?			
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)?			
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?			
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?			
22. Have you ever become ill while exercising in the heat?			
23. Do you or does someone in your family have sickle cell trait or disease?			
24. Have you ever had or do you have any problems with your eyes or vision?			

MEDICAL QUESTIONS (CONTINUED)		Yes	No
25. Do you worry about your weight?			
26. Are you trying to or has anyone recommended that you gain or lose weight?			
27. Are you on a special diet or do you avoid certain types of foods or food groups?			
28. Have you ever had an eating disorder?			
FEMALES ONLY		Yes	No
29. Have you ever had a menstrual period?			
30. How old were you when you had your first menstrual period?			
31. When was your most recent menstrual period?			
32. How many periods have you had in the past 12 months?			

**Explain "Yes" answers here.**

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**I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.**

Signature of athlete: \_\_\_\_\_

Signature of parent or guardian: \_\_\_\_\_

Date: \_\_\_\_\_



■ PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

PHYSICIAN REMINDERS

- 1. Consider additional questions on more-sensitive issues.
• Do you feel stressed out or under a lot of pressure?
• Do you ever feel sad, hopeless, depressed, or anxious?
• Do you feel safe at your home or residence?
• During the past 30 days, did you use chewing tobacco, snuff, or dip?
• Do you drink alcohol or use any other drugs?
• Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
• Have you ever taken any supplements to help you gain or lose weight or improve your performance?
• Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (Q4-Q13 of History Form).

Table with columns: EXAMINATION, MEDICAL, MUSCULOSKELETAL, NORMAL, ABNORMAL FINDINGS. Rows include: Height, Weight, BP, Pulse, Vision, Corrected, Appearance, Eyes, ears, nose, and throat, Lymph nodes, Heart, Lungs, Abdomen, Skin, Neurological, Neck, Back, Shoulder and arm, Elbow and forearm, Wrist, hand, and fingers, Hip and thigh, Knee, Leg and ankle, Foot and toes, Functional.

° Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of health care professional: \_\_\_\_\_, MD, DO, NP, or PA