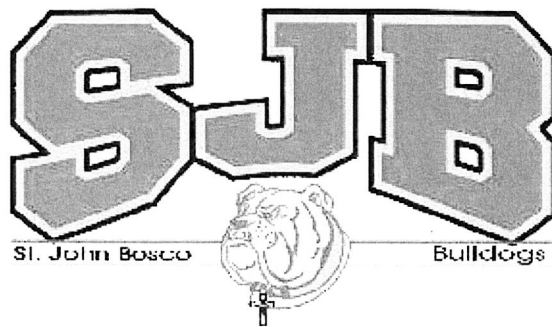


## CYAA Sports Permission Form



I/We, the parent(s)/guardian(s) of \_\_\_\_\_ request that my child participate in the CYAA after school program at St. John Bosco. I understand that this will include travel to other schools and the parent/guardian is responsible for transportation. Also, due to league fees, and the cost of officials, each participant will be asked to pay \$75.00 per sport (paid through FACTS). This is a **non-refundable** fee to those who drop out of the program, those who are suspended, and those who are academically ineligible due to grades or conduct.

\_\_\_\_\_  
Parent / Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Daytime phone

Check Sports for participation:

Boys: \_\_\_\_\_ Flag Football

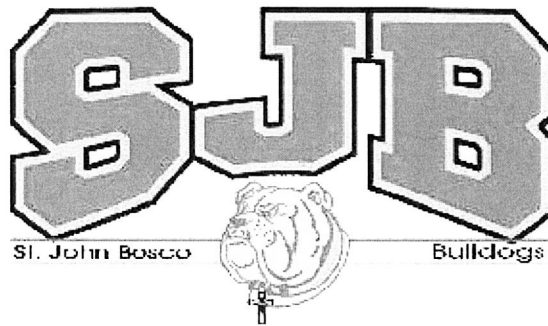
Boys: \_\_\_\_\_ Basketball

Boys: \_\_\_\_\_ Baseball

Girls: \_\_\_\_\_ Volleyball

Girls: \_\_\_\_\_ Softball

Girls: \_\_\_\_\_ Basketball



### **Code of Conduct – Student Athlete**

All eligible student-athletes are encouraged to participate in the various CYAA activities. Students who choose to participate in CYAA activities must make a commitment to their team. To play on a CYAA school team is both a privilege and responsibility.

Any student-athlete participating in a CYAA activity is expected to:

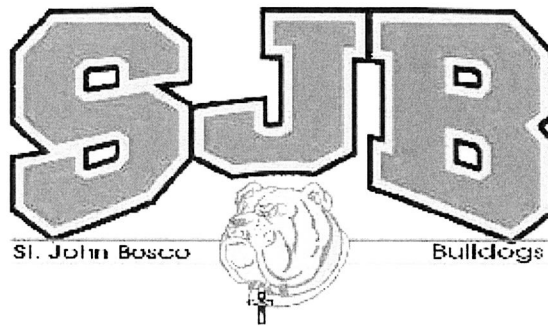
- Give fully of himself/herself during practice & games.
- Be accepting of his/her honest mistakes.
- Strive to win without placing undue pressure on self and/or teammates.
- Recognize and respect the strengths and weaknesses of teammates.
- Exhibit sportsmanship at ALL times – being a good winner as well as a good loser.
- Accept the guidance of coaches.
- Respect the decisions of officials and umpires.
- Refrain from offensive language and actions.
- Maintain a satisfactory academic record with no D's or F's as well as satisfactory behavior. This is a minimum standard ONLY and a parent may choose to adopt a higher standard for their student-athlete. This will provide the best learning environment for that individual student.
- Not attend practice or games if ineligible.
- Accept the responsibility of good behavior on campus & in the classroom at all times. Should there be a discipline notice given in the form of an STP or Office Referral then the school discipline policy comes into effect.

I have read the Code of Conduct and agree to follow the guidelines listed above.

---

Student Signature

Date



### **Code of Conduct – Parent/Guardians**

Parents of children participating in the CYAA Program should be made aware of the philosophy and guidelines as presented in the CYAA Handbook. ([www.diocesephoenix.org/schools/cyaa/handbook](http://www.diocesephoenix.org/schools/cyaa/handbook))

Parents/Guardians of student athletes are expected to:

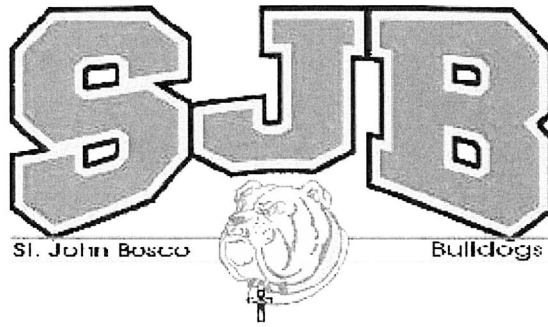
- Have a positive influence as spectators of the game. Parents should support coaches, officials, and players regardless of a win or loss.
- Should be an example of cooperation and respect.
- A parent/guardian who observes a coach whose behavior is not consistent with the CYAA guidelines or philosophy should make it known to the school Athletic Director, Principal, and CYAA Advisory Board in writing.
- Refrain from offensive language and actions at all times. Taunting and/or swearing are not to be tolerated in the CYAA Sports Program. Actions of this nature will result in dismissal from activity.
- Exhibit sportsmanship at ALL times – being a good winner as well as a good loser.
- Respect the decisions of officials and umpires.
- Understand that students are expected to maintain satisfactory grades as listed in the Student Code of Conduct.

I have read the Code of Conduct listed above and agree to comply within established standards.

---

Parent Signature

Date



## Consent for EMERGENCY CARE

As parent/guardian of \_\_\_\_\_ I do hereby give and grant to any medical doctor or hospital my consent for medical treatment for my child, in the event he/she should become ill or injured while participating in an interscholastic activity.

I understand that payment for any charges incurred is not the responsibility of St. John Bosco Catholic School.

Family Physician \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Policy/Group # \_\_\_\_\_

Home Address \_\_\_\_\_

Home Phone \_\_\_\_\_

Emergency Contact Phone Number \_\_\_\_\_

Mother Cell \_\_\_\_\_ Work \_\_\_\_\_

Father Cell \_\_\_\_\_ Work \_\_\_\_\_

In the event that we cannot reach Mother/Father please provide two additional emergency contacts.

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

\_\_\_\_\_  
Parent / Guardian signature Date

\_\_\_\_\_  
Parent / Guardian Signature Date

**St. John Bosco Catholic School**  
**Mild Traumatic Brain Injury (MTB / Concussion)**  
**Annual Statement and Acknowledgement Form**

I, \_\_\_\_\_ (student), acknowledge that I have to be an active participant in my own health and have the direct responsibility for reporting all my injuries and illnesses to the school staff (e.g., coaches, Athletic Director). I further recognize that my physical condition is dependent upon providing an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries and /or disabilities experienced before, during or after athletic activities.

By signing below, I acknowledge:

St. John Bosco Catholic School has provided me with specific educational materials including the CDC Concussion fact sheet.

- I have fully disclosed to the staff and my physician any prior medical conditions and will also disclose any future conditions.
- There is a possibility that participation in my sport may result in a head injury and/or concussion. In rare cases, these concussions can cause permanent brain damage, and even death.
- A concussion is a brain injury, which I am responsible for reporting to the Athletic Director.
- A concussion can affect my ability to perform everyday activities and affect my reaction time, balance, sleep and classroom performance.
- Some of the symptoms of concussion may be noticed right away while other symptoms can show up hours or days after the injury.
- If I suspect a teammate has a concussion, I am responsible for reporting the injury to the school staff.
- I will not return to play in a game or practice if I have received a blow to the head or body that may result in concussion related symptoms.
- I will not return to play in a game or practice until my symptoms have resolved AND I have written clearance to do so by a qualified health care professional.
- Following concussion, the brain needs time to heal and you are much more likely to have a repeat concussion or further damage if you return to play before your symptoms resolve.

Based on the incidence of concussion as published by the CDC, the following sports have been identified as high risk for concussion: baseball, basketball, football, soccer, softball, spirit-line and wrestling.

I represent and certify my parent/guardian and I have read the entirety of this document and fully understand the contents, consequences and implications of signing this document and that I agree to be bound by this document.

Student Athlete:

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_

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

Parent or legal guardian:

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_

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



**Roman Catholic Diocese of Phoenix**  
**TRANSPORTATION OF MINOR PERSON TO/FROM SCHOOL CAMPUS**

The Catholic Diocese of Phoenix "Diocesan Policy and Procedure for the Protection of Minors" as it pertains to Diocesan Personnel provides, in part, that "Field trips or other outings involving a minor in places and situations where no other responsible adults are present..." are to be avoided. The directive of this provision requires that another adult should accompany Diocesan personnel who transport minors to and from field trips and outings.

Because of the limited number of participants in the \_\_\_\_\_ (name of program) of \_\_\_\_\_ (name of school) and the time of day in which program events will occur, it may not always be possible to have two adults occupying each vehicle transporting minors to and from the programs.

The Diocese permits **exceptions to this policy** only upon a showing by the school that:

1) a school has made reasonable efforts to have two adults present in such vehicles, but without success; and 2) a parent or guardian of any student participating in such program has consented in writing to allow such student to be transported in a vehicle occupied by only one adult. However, for the exception to apply the parent/guardian of the minor person must consent in writing.

I, \_\_\_\_\_, of \_\_\_\_\_  
 (name of parent/guardian) (name of minor student)

have selected one of three alternatives below by checking the applicable box to indicate selection:

☐ (1) **CONSENT OF PARENT/GUARDIAN TO ALLOW FOR EXCEPTION TO POLICY.**

I, \_\_\_\_\_, parent/guardian of \_\_\_\_\_, (name of student) a participant in the \_\_\_\_\_ (name of program) of \_\_\_\_\_ (name of school) hereby consent to allow the student named above to travel to and from program events in a vehicle occupied by a single adult person at any time during the \_\_\_\_\_ school year. I further acknowledge that I have instructed my minor child to occupy only the rear seat(s) of such vehicle. I agree that if I wish to revoke this consent I will do so in writing and deliver such revocation to the Principal of the school. I further consent subject to the following additional conditions (if any): \_\_\_\_\_

☐ (2) **NON-EXCEPTION**

I, \_\_\_\_\_, parent/guardian of \_\_\_\_\_, choose to have my child always travel in a 2 adult vehicle.

☐ (3) **ASSUMPTION OF TRANSPORTATION RESPONSIBILITY**

I, \_\_\_\_\_, parent/guardian of \_\_\_\_\_, will solely provide transportation for my child to all activities away from the school campus.

\_\_\_\_\_  
 (signature of parent/guardian)

\_\_\_\_\_  
 (print name of parent/guardian)

State of Arizona

County of \_\_\_\_\_

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
 Notary Public

My commission expires: \_\_\_\_\_

**Roman Catholic Diocese of PHoenix**  
**driver information form**

(Please Type or Print)

**DRIVER INFORMATION**

Driver Last Name:	First Name:	Middle Initial	Date of Birth
Street address:	City:	State:	Zip Code:
Phone #:	Drivers License #:	State:	Expiration Date:

In order to provide for the safety of our students, we must ask each volunteer drive to list all accidents or moving violations you have had in the past five (5) years:

**VEHICLE INFORMATION**

Name of Owner:			
Owner Street address:	City:	State:	Zip Code:
License Plate #:	State:	Date of Expiration:	
Model of Vehicle:	Make of Vehicle:	Year of Vehicle:	

**If more than one vehicle is to be used, the above information must be provided for each vehicle.**

**INSURANCE INFORMATION**

When using a privately owned vehicle, the insurance coverage is the limit of the insurance policy covering that specific vehicle.

Insurance Company:	Policy #:	Date of Expiration:
Liability Limits of Policy*:		

**\*Please Note: The minimum acceptable limits for privately owned vehicles are \$100,000/\$300,000.**

**CERTIFICATION**

I certify that the information given on this form is true and correct to the best of my knowledge. I understand that as a volunteer driver, I must be 21 years of age or older. I must be 25 years of age or older to transport minors. I must possess a valid driver's license, have the proper and current license and vehicle registration and have the required insurance coverage in effect on any vehicle used.

*Signature*

*Date*

St. John Bosco Catholic School  
16035 S. 48<sup>th</sup> St. Phoenix, AZ 85048  
480-219-4848

(The Parent or Guardian should fill out this form with assistance from the student athlete.)

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

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

Personal Physician \_\_\_\_\_ Hospital Preference \_\_\_\_\_

*Explain "Yes" answers below.*

*Circle questions you don't know the answers to.*

	Yes	No
Have you had a medical illness or injury since your last check-up or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have an ongoing or chronic illness?	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently being treated for an injury or condition?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been hospitalized overnight?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently taking any prescription or non-prescription (over the counter) medications, pills or using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any allergies to medications?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any allergies to pollen, food or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a rash or hives develop during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get tired more quickly than your friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a severe viral infection (i.e., mononucleosis or myocarditis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
Has a doctor ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone in your immediate family had the following conditions? Diabetes <input type="checkbox"/> Heart disease <input type="checkbox"/> Sudden death <input type="checkbox"/> High blood pressure <input type="checkbox"/>		
Do you have any current skin problems (itching, rashes, acne, warts, fungus or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Do you cough, wheeze or have trouble breathing during or after activity?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on teeth or hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear glasses, contacts or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a strain, sprain or swelling after injury?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever fractured any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any problems with pain or swelling in your muscles, tendons, bones or joints?	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, check appropriate box below.</i>		
<input type="checkbox"/> Head	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip
<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh
<input type="checkbox"/> Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Knee
<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Shin
<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger	<input type="checkbox"/> Ankle
<input type="checkbox"/> Upper arm	<input type="checkbox"/> Calf	<input type="checkbox"/> Foot
Do you want to weigh more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>
Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel stressed?	<input type="checkbox"/>	<input type="checkbox"/>
Do you or have you ever used		
Smokeless tobacco <input type="checkbox"/> Cigarettes <input type="checkbox"/> Alcohol <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreational drugs <input type="checkbox"/>		

**FEMALES ONLY**

When was your first menstrual period? \_\_\_\_\_

When was your most recent menstrual period? \_\_\_\_\_

How much time do you usually have from the start of one period to the start of another? \_\_\_\_\_

How many periods have you had in the last year? \_\_\_\_\_

What was the longest time between periods last year? \_\_\_\_\_

Explanation: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. I understand and acknowledge that truthful and accurate information is essential in properly determining whether the student should be cleared for athletic participation.

Signature of Parent/Guardian \_\_\_\_\_

Signature of Student Athlete \_\_\_\_\_

Date \_\_\_\_\_



# ANNUAL PRE-PARTICIPATION PHYSICAL EVALUATION

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ ( \_\_\_\_\_ / \_\_\_\_\_ . \_\_\_\_\_ / \_\_\_\_\_ )

Vision R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Corrected: Y N Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

NORMAL		ABNORMAL FINDINGS	INITIALS
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Hearing			
Lymph Nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary *			
Skin			
MUSCOLOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			

\*Having a third party present is recommended for the genitourinary examination.

Notes: \_\_\_\_\_  
 \_\_\_\_\_

☐ Cleared without restriction

☐ Not cleared for: ☐ All sports ☐ Certain sports Reason: \_\_\_\_\_

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

Name of Physician (print) \_\_\_\_\_ Date \_\_\_\_\_

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

Signature of Physician \_\_\_\_\_, MD / DO / NP / PA-C