ATHLETIC DIRECTOR: MR. DANIEL THREADGILL | 909 623 5297 EXT 33 | DTHREADGILL@POMONACATHOLIC.ORG

POMONA CATHOLIC HIGH SCHOOL ATHLETIC DEPARTMENT

PARTICIPATION CONTRACT

STUDENT'S NAME ______________________ GRADE ______________

PARENT/GUARDIAN NAME ______________________ SPORTS ______________

STUDENT AGREEMENT:

I, ________________________________ understand that participating in any extra-curricular activity can be both physically demanding and time consuming. In order to commit to a full season of my athletic team of choice, I understand I must stay eligible with 2.0 GPA or greater in academics, I must maintain the Pacer code of conduct and have performed all obligations with the dean of discipline, or I can be suspended or removed from the team. I understand that practices can be up to 6 days a week up to 2 ½ hours long, with games and/or tournaments after school and sometimes on Saturdays. These games can be several hours away, and I will need to balance academics and athletics to the best of my ability. I will keep school work my priority; however, I will not use school work as an excuse to miss practices and/or games. It is my responsibility as a student athlete to manage my time and my commitments. If I have a previous commitment (confirmation classes, etc.), I will notify the head coach once I have been placed on the team roster. Not showing up to practices or games without notification can result in my suspension or removal from the team. See rules listed below.

PARENT AGREEMENT:

I, ________________________________ understand the commitment that my student athlete is making by participating on an athletic team. I understand that any extra-curricular activity can be both physically demanding and time consuming. In order to commit to a full season of their team of choice, I understand that my student athlete must stay eligible in academics, financially and upholding the Pacer code of conduct, or they can be suspended or removed from the team. I understand that practices can be up to 6 days a week with games and/or tournaments after school, on Saturdays, and over holiday breaks. It is my responsibility as the parent of a student athlete to help my student athlete manage their time and commitments. It is also my responsibility to ensure they can get to and from practices and games.

*We understand that play time is determined by the coach, keeping in mind that some athletes may have very little play time.

PARTICIPATION ELIGIBILITY:
Participation eligibility requires that the athletic fees are paid within 10 days of being placed on the roster and that ALL other tuition and fees are current and account is in good standing.

The cost for participating in any sport is **$375.00** ($225 for each additional sport). Due 10 days after student athlete is placed on roster in order to maintain eligibility. Also, each athlete is required to participate on the fundraiser chosen for their sport or by the athletic department.

MISSED GAMES OR PRACTICES:

+ **No more than 5 absences** (excused or unexcused) are allowed in order to letter or receive varsity credits. An excused absence includes: illness (only if you are absent all day), religious activities, family vacations, school field trips, and staying after school with teachers. (Signed notes, schedules, and itineraries are required where applicable.)
+ If an injury has occurred, the athlete is required to show up to practices and games so that they remain on the team.
+ **If athlete quits or is dismissed fromthe team,**
  1) Athlete is still responsible for athletic fee.
  2) Athlete may not Participate in any other sport for the next two seasons.

PARENT SIGNATURE ______________________ DATE ____________

STUDENT SIGNATURE ______________________ DATE ____________

POMONA CATHOLIC HIGH SCHOOL & MIDDLE SCHOOL ATHLETIC DEPARTMENT

ATHLETIC TRAVEL PERMIT

ATHLETIC DIRECTOR: MR. DANIEL THREADGILL | **909 623 5297** EXT **33** | DTHREADGILL@POMONACATHOLIC.ORG

I understand that my daughter____ , will travel by bus: if a bus is not available, by car or school van with a parent, teacher, or coach driver to any athletic event. As a condition of being permitted to do so, I release and discharge the school and its employees from any claims for personal injuries or property damage that my daughter may suffer as a result of participation in the athletic team activities or transportation. I agree to relieve the school and other participating adults from any liability in connection with this request.

I understand that my daughter will not be allowed to drive herself to athletic events. Should this be necessary, a note from the parent requesting this permission must be given to the athletic director on the day prior to the event.

I also understand that no students will be allowed to ride with student drivers.

This permission shall remain in effect for one year unless revoked in writing to the principal.

____ ___________________

PARENT OR LEGAL GUARDIAN SIGNATURE DATE

HISTORY FORM

PREPARTICIPATION PHYSICAL EVALUATION

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DATE OF EXAM ____________

NAME ____________

☐ MALE ☐ FEMALE DATE OF BIRTH ____________ AGE ____________

GRADE ____________ SCHOOL ____________ SPORT ____________

ADDRESS ____________ PHONE ____________

PERSONAL PHYSICIAN ____________ PHONE ____________

IN CASE OF EMERGENCY, CONTACT:

REVISED 7/1/05
MANDATORY

NAME ____________ RELATIONSHIP ____________ PHONE (H) ____________ PHONE (W) ____________

EXPLAIN "YES" ANSWERS BELOW. CIRCLE QUESTIONS YOU DON'T KNOW THE ANSWERS TO.

	YES	NO
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2. Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	☐
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5. Have you ever passed out or nearly passed out DURING exercise?	☐	☐
6. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
8. Does your heart race or skip beats during exercise?	☐	☐
9. Has a doctor ever told you that you have (check all that apply): ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection	☐	☐
10. Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)	☐	☐
11. Has anyone in your family died for no apparent reason?	☐	☐
12. Does anyone in your family have a heart problem?	☐	☐
13. Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
14. Does anyone in your family have Marfan syndrome?	☐	☐
15. Have you ever spent the night in a hospital?	☐	☐
16. Have you ever had surgery?	☐	☐
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below:	☐	☐
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	☐	☐
19. Have you had a bone or joint injury that required x-rays MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:		

HEAD	NECK	SHOULDER	UPPER ARM	ELBOW	FOREARM	HAND+ FINGERS	CHEST
UPPER BACK	LOWER BACK	HIP	THIGH	KNEE	CALF+ SHIN	ANKLE	FOOT+ TOES

	YES	NO
20. Have you ever had a stress fracture?	☐	☐
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
22. Do you regularly use a brace or assistive device?	☐	☐
23. Has a doctor ever told you that you have asthma or allergies?	☐	☐
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
25. Is there anyone in your family who has asthma?	☐	☐
26. Have you ever used an inhaler or taken asthma medicine?	☐	☐
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
28. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
29. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
30. Have you had a herpes skin infection?	☐	☐
31. Have you ever had a head injury or concussion?	☐	☐
32. Have you been hit in the head and been confused or lost your memory?	☐	☐
33. Have you ever had a seizure?	☐	☐
34. Do you have headaches with exercise?	☐	☐
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
36. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
37. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
39. Have you had any problems with your eyes or vision?	☐	☐
40. Do you wear glasses or contact lenses?	☐	☐
41. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
42. Are you happy with your weight?	☐	☐
43. Are you trying to gain or lose weight?	☐	☐
44. Has anyone recommended you change your weight or eating habits?	☐	☐
45. Do you limit or carefully control what you eat?	☐	☐
46. Do you have any concerns that you would like to discuss with a doctor?	☐	☐

FEMALES ONLY:

	YES	NO
47. Have you ever had a menstrual period?	☐	☐

48. How old were you when you had your first menstrual period? ____________

49. How many periods have you had in the last 12 months? ____________

EXPLAIN "Yes" answers here: ____________

____

____

I HEREBY STATE THAT, TO THE BEST OF MY KNOWLEDGE, MY ANSWERS TO THE ABOVE QUESTIONS ARE COMPLETE AND CORRECT.

ATHLETE (SIGNATURE) ____________ PARENT/GUARDIAN (SIGNATURE) ____________ DATE ____________

PHYSICAL EXAMINATION FORM

PREPARTICIPATION PHYSICAL EVALUATION

NAME ____________________________________ DATE OF BIRTH ______________

HEIGHT __________ WEIGHT __________ % BODY FAT (OPTIONAL) __________ PULSE __________

BP ________/________ (________/________ , ________/________)

VISION R20/________ L20/________ 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 (MALES ONLY)+			
SKIN			
MUSCULOSKELETAL			
NECK			
BACK			
SHOULDER/ARM			
ELBOW/FOREARM			
WRIST/HAND/FINGERS			
HIP/THIGH			
KNEE			
LEG/ANKLE			
FOOT/TOES			

*Multiple-examiner set-up only. +Having a third party present is recommended for the genitourinary examination.

NOTE: ____

NAME OF PHYSICIAN (PRINT/TYPE) ______________________ DATE __________

ADDRESS ______________________ PHONE __________

SIGNATURE OF PHYSICIAN ______________________, MD OR DO

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CLEARANCE FORM

PREPARTICIPATION PHYSICAL EVALUATION

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CLEARANCE FORM

NAME ____________ SEX ______ AGE ______ DATE OF BIRTH ______

☐ **CLEARED** WITHOUT RESTRICTION

☐ **CLEARED,** WITH RECOMMENDATIONS FOR FURTHER EVALUATION OR TREATMENT

FOR: ____________________

☐ **NOT CLEARED FOR:** ☐ **ALL SPORTS** ☐ **CERTAIN SPORTS:** ____________

REASON: ____________________

RECOMMENDATIONS: ____________________

EMERGENCY INFORMATION:

ALLERGIES ____________________

OTHER INFORMATION ____________________

NAME OF PHYSICIAN (PRINT/TYPE) ____________ DATE ______

ADDRESS ____________ PHONE ______

SIGNATURE OF PHYSICIAN ____________, MD OR DO

CLEARANCE FORM

NAME ____________ SEX ______ AGE ______ DATE OF BIRTH ______

☐ **CLEARED** WITHOUT RESTRICTION

☐ **CLEARED,** WITH RECOMMENDATIONS FOR FURTHER EVALUATION OR TREATMENT

FOR: ____________________

☐ **NOT CLEARED FOR:** ☐ **ALL SPORTS** ☐ **CERTAIN SPORTS:** ____________

REASON: ____________________

RECOMMENDATIONS: ____________________

EMERGENCY INFORMATION:

ALLERGIES ____________________

OTHER INFORMATION ____________________

NAME OF PHYSICIAN (PRINT/TYPE) ____________ DATE ______

ADDRESS ____________ PHONE ______

SIGNATURE OF PHYSICIAN ____________, MD OR DO