

Catholic Community of Jeffersonville: St. Augustine-Sacred Heart High School Youth Athletics VOLLEYBALL Registration Form 2009 - 2010 Sports Seasons

All 9th -12th grade youth of St. Augustine-Sacred Heart are invited to play on our volleyball team. Practices will be on Thursdays from 6-8pm beginning on Thursday, February 11th in the Sacred Heart Gym. Games are on Sundays beginning February 14-March 28, 2010. Games take place for one hour sometime between 1:00-5:00pm in various locations in the New Albany Deanery parish gyms.

Cost is \$15 per participant (registration & t-shirt)

Uniform: Each participant will receive a t-shirt

You are asked to check the space below saying that you are an **active member of your parish community** – meaning you attend Mass on a regular basis (4:00pm at St. Augustine on Saturdays, 5:45pm at Sacred Heart on Saturdays, 8:30am at St. Augustine on Sundays and 11am at Sacred Heart on Sundays) and participate in parish events such as the Lenten Event.

Name _____ **Date of Birth** _____ **Grade** _____

Address _____ **Parish** _____ **School** _____

City/St/Zip _____ **Home Phone** _____ **Date of Physical** _____

____ Yes, I am an active member

T-Shirt Size: Adult-Small _____ Adult-Medium _____ Adult-Large _____ Adult-X-Large _____

Parent Name _____ **Cell Phone** _____ **E-Mail** _____

Participants Name _____ **Cell Phone** _____ **E-Mail** _____

Please place a checkmark on the blank by the sport you are registering for:

_____ **Basketball-Boys (9-12) \$40.00 Fee**
Registration due-November 10, 2009

_____ **Volleyball-Co-ed (9-12) \$15 Fee**
Registration due-February 4, 2010

_____ **Softball (8th grade graduates – graduating seniors) \$10 Fee**
Registration due TBA

Fees (\$15 for volleyball) are due at the time of registration. Please make check payable to "Sacred Heart". **Return completed Registration Form, Payment, and Medical Exam to the Parish Center- Youth Ministry Office by Thursday, February 4, 2010. All registrations and payments need to be turned in to the Youth Ministry Office.** Late registrations will be subject to a \$10 late fee and may affect eligibility. Registrations will not be accepted at practices or by coaches.

Parent Signature _____ **Date** _____

Please list the name of any adult who may be interested in coaching: **Head Coach** _____ **Phone** _____ **Sport:** _____
Assistant Coach _____ **Phone** _____ **Sport:** _____

YM OFFICE USE ONLY: Check # _____ Check \$ _____ Date Deposited: _____ Acct # _____
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PHYSICIAN'S CERTIFICATE
New Albany Deanery Catholic Youth Ministries
Athletics Program

Prior to a youth participants' first practice in their chosen sport, he/she will have this form completed by their family physician and returned to their coach. This form verifies a physical examination indicating fitness for this young person to participate in athletics.

The forms must be completed each year at the beginning of the school year and are good for all sports during that school year. After each season, the coach should turn this form over to the athletic rep so it may be passed on to the next coach as appropriate.

I have examined _____

Parish _____ Grade _____

Heart: _____ Blood Pressure: _____

Lungs: _____ Back: _____

Extremities: _____ Hernia: _____

General Physical Condition: _____

In my opinion the above named is physically capable of participating in Catholic Youth Ministries athletics.

Physician's Signature _____ Date _____

**St. Augustine/Sacred Heart Youth Ministry Permission Form
January 2010-December 2010**

Name: _____ Date of Birth: ___/___/___

Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

E-mail: _____ Youth Cell Phone #: _____

Persons to contact in case of emergency:

1. Name: _____ Relation: _____ Primary Phone #: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

2. Name: _____ Relation: _____ Primary Phone #: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

As parent or guardian of the above named youth, I have hereby released the Archdiocese of Indianapolis, St. Augustine and Sacred Heart Parishes, New Albany Deanery Youth Ministries, parish staff and/or volunteer leaders from any claim, loss, cost, damage, or expense arising out of any accident or other occurrence causing injury to any person or property during this outing. In case of accident or sickness, the adult in charge has my permission to secure medical attention for my child. Further, should it be necessary for the participant to return home due to medical reasons, disciplinary action, or otherwise, I hereby assume all transportation costs.

Parent/Guardian Signature: _____ Date: ___/___/___

Work Phone: _____ Cell Phone: _____

E-mail address of Parent/Guardian: _____

Make check payable to: St. Augustine or Sacred Heart Youth Ministry (If Applicable)

PHOTO RELEASE FORM

During most youth ministry activities, St. Augustine and Sacred Heart Parishes take photos and/or gather quotes for use in our public relations efforts, such as website, brochures, newsletters, etc. We would request all parents and guardians sign the release below stating that you grant your permission for us to use photographs or quotations of your son or daughter. Thank you!

Children's names: _____

I give my permission for photographs taken during Parish activities of my son/daughter as well as any quotations given from my son/daughter to a media representative to be used for public relations efforts of the Parish/Deanery. ___ yes ___ no

Parent/Guardian Signature: _____ Date: ___/___/___

**St. Augustine/Sacred Heart Youth Ministry Medical Release Form
January 2010-December 2010**

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Date of Birth: ____/____/____

Persons to contact in case of emergency:

1. Name: _____ Relation: _____ Primary Phone #: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

2. Name: _____ Relation: _____ Primary Phone #: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Insurance Company: _____ Name of Insured: _____

Policy Number: _____ Family Physician: _____

Physician Phone Number: _____ Date of Last Tetanus Shot: _____

Date of Last Physical: _____

Allergic to: _____

Medications: _____

If you do not have health insurance, please contact: _____ phone: _____

I, the undersigned parent or guardian of _____ a minor, do hereby authorize the adult(s) representing the St. Augustine and Sacred Heart Parishes as my agents, to consent in case of a medical emergency to any examinations, x-ray, anesthetic, medical, or surgical diagnosis or treatment and hospital care deemed advisable by a qualified physician or local hospital. An authorized parish adult agrees to contact the undersigned as soon as possible if an emergency should arise. I will assume responsibility for fees incurred by such an emergency. In addition, I certify that the above information is correct and give permission for the release of medical records to the attending physician. I realize that I cannot hold the St. Augustine or Sacred Heart Parishes, the New Albany Deanery Youth Ministries Office, nor the Archdiocese of Indianapolis responsible for such an emergency.

Parent/Guardian Signature: _____ Date: ____/____/____

Work Phone: _____ Cell Phone: _____