

**Saint David Catholic School**

**Student Athletic Handbook**

**2023-2024**





Dear Parents,

Enclosed are two forms pertaining to the All Broward Catholic Conference, our Archdiocesan elementary school athletic association. We ask that you have both forms completed each year after June 15 or before the first day of tryouts. **Only after these forms have been submitted is your child permitted to participate in the athletic events conducted by the All Broward Catholic Conference.**

The Athletic Consent and Release from Liability Certificate must be completed by the student's parent or guardian and the Athletic Pre-participation Physical Evaluation form must be completed by a licensed physician (MD or DO).

Please note that the Athletic Pre-participation Physical Evaluation Form will be used ONLY for the purpose of determining a student's athletic eligibility.

Thank you for your cooperation.

Sincerely,

*Mrs. Michelle Chimienti*

Michelle Chimienti

Principal

Saint David Catholic School

## **HANDBOOK FOR STUDENT ATHLETES AND PARENTS**

### **STUDENT ATHLETE BEHAVIOR:**

All Saint David Student Athletes are expected to maintain high academic and behavior standards. Behavior as stated in the Saint David Student Handbook will be followed at all times. Players wearing the Saint David uniform represent the school and their behavior should reflect the Mission and Beliefs of Saint David Catholic School. If at any time a student's behavior becomes unacceptable, the student may be dismissed from the team/squad.

### **FEES:**

There will be an athletic fee of \$100 for each sport (except Track and Cross Country which is \$50.00). The fee covers the expenses of each sport (umpires and referee fees, tournament fees, team trophies and the cost of athletic banquets).

### **GRADES:**

A student may be withheld from the next scheduled practice or game if his/her grade in a school subject falls to a "D" or lower. Upon receipt of information from the teacher(s) of the subject(s) verifying that the student has shown improvement in effort, the students may return to eligible status. It is the responsibility of the Athletic Director, not the team coach, to check on the status of an ineligible student each week. The student will remain ineligible until notification from the teacher(s) is received.

### **SCHOOL ATTENDANCE:**

A student must be in school by 11:00 AM to be eligible to participate in that day's practice or game. If a student leaves school early because of illness, the student is ineligible to participate.

### **UNIFORMS:**

No team uniform shall be worn to P.E. class. Players may cover their team uniforms with a school shirt or school P.E. shirt.

Do not alter the uniform in any way.

Team uniforms need to be washed and turned in at the end of each season. If the student does not turn in his/her uniform, report card(s) will be withheld.



Archdiocese of Miami  
Department of Schools  
**Athletic Consent and Release from Liability Certificate**  
This completed form must be kept on file by the school

Student Name: \_\_\_\_\_

School: \_\_\_\_\_

Sport(s) in which student plans to participate: \_\_\_\_\_

- 
- A. I/We hereby give consent for child/ward to participate in the interscholastic sport(s) that I/we have listed above.
- B. I/We know of and acknowledge that my/our child/ward knows of the risks involved in athletic participation, understands that serious injury, and even death, is possible in such participation and choose to accept any and all responsibility for his/her safety and welfare while participating in athletics. With full understanding of the risks involved, I/we release and hold harmless my/our child's/ward's school, the schools against it competes, the contest officials and the Archdiocese of Miami of any and all responsibility and liability for any injury or claim resulting from such athletic participation and agree to take no legal action against my/our child's/ward's school, the schools against which it competes, the contest officials and the Archdiocese of Miami because of any accident or mishap involving the athletic participation of my/our child/ward. I/We further authorize emergency medical treatment for my/our child/ward should the need arise for such treatment while my/our child/ward is under the supervision of the school.

**C. Insurance Information**

My/Our child/ward is covered under our family health insurance plan which has limits of not less than \$25,000.

Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

**I/WE HAVE READ THIS CAREFULLY AND KNOW IT CONTAINS A RELEASE:**

Date: \_\_\_\_\_ Signature of Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_ Signature of Parent/Guardian: \_\_\_\_\_



**Part 1. Student Information (to be completed by the parent/guardian).**

Student Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 School: \_\_\_\_\_ Grade in School: \_\_\_\_\_ Sport(s) expected to play: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_  
 Name of Parent/Guardian: \_\_\_\_\_  
 Person to Contact in Case of Emergency: \_\_\_\_\_  
 Relationship to Student: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

**Part 2. Medical History (to be completed by parent/guardian). Explain "yes" answers below. Circle questions for which you do not know the answer.**

	Yes	No		Yes	No
1. Has child had a medical illness or injury since the last check up or sports physical?	___	___	24. Has child ever had numbness or tingling in his/her arms, hands, legs, or feet?	___	___
2. Does child have an ongoing chronic illness?	___	___	25. Has child ever has a stinger, burner, or pinched nerve?	___	___
3. Has child ever been hospitalized overnight?	___	___	26. Has child ever become ill from exercising in the heat?	___	___
4. Has child ever had surgery?	___	___	27. Does child cough, wheeze or have trouble breathing during or after activity?	___	___
5. Is child currently taking any prescription or nonprescription (over the counter) medications or pill or using an inhaler?	___	___	28. Does child have asthma?	___	___
6. Has child ever taken any supplements or vitamins to help gain or lose weight or improve performance?	___	___	29. Does child have seasonal allergies that require medical treatment?	___	___
7. Does child have any allergies (for example to pollen, medicine, food, or stinging insects)?	___	___	30. Does child have 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 your teeth, hearing aid)?	___	___
8. Has child ever had rash or hives develop during or after exercise?	___	___	31. Has child had any problems with his/her eyes or vision?	___	___
9. Has child ever passed out during or after exercise?	___	___	32. Does child wear glasses, contacts or protective eyewear?	___	___
10. Has child ever been dizzy during or after exercise?	___	___	33. Has child ever had a sprain, strain or swelling after injury?	___	___
11. Has child ever had chest pain during or after exercise?	___	___	34. Has child broken or fractured any bones or dislocated any joints?	___	___
12. Does child get tired more quickly than friends during exercise?	___	___	35. Has child had any other problems with pain or swelling in muscles, tendons, bones, or joints?	___	___
13. Has child ever had racing of the heart or skipped heartbeats?	___	___	If yes, check appropriate blanks and explain below:		
14. Has child had high blood pressure or high cholesterol?	___	___	___ Head	___ Elbow	___ Hip
15. Has child ever been told he/she has a heart murmur?	___	___	___ Neck	___ Forearm	___ Thigh
16. Has any family member or relative died of heart problems or sudden death before age 50?	___	___	___ Back	___ Wrist	___ Knee
17. Has child had severe viral infection (for example, myocarditis or mononucleosis) within the last month?	___	___	___ Chest	___ Hand	___ Shin/Calf
18. Has a physician ever denied or restricted child's participation in sports for any heart problems?	___	___	___ Shoulder	___ Finger	___ Ankle
19. Does child have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	___	___	___ Upper Arm	___ Foot	
20. Has child ever had a head injury or concussion?	___	___	36. Does child want to weigh more or less than child weighs now?	___	___
21. Has child ever been knocked out, become unconscious, or lost his/her memory?	___	___	37. Does child lose weight regularly to meet weight requirements for a sport?	___	___
22. Has child ever had a seizure?	___	___	38. Does child feel stressed out?	___	___
23. Does child have frequent or severe headaches?	___	___	39. Record the dates of his/her most recent immunizations (shots) for:		
			Tetanus _____	Measles _____	
			Hepatitis B _____	Chickenpox _____	

Explain "Yes" answers here: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I hereby state, to the best of my knowledge, that my answers to the above questions are complete and correct.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



**Part 3. Physical Examination (to be completed by the physician).**

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ % Body Fat (optional): \_\_\_\_\_ Pulse: \_\_\_\_\_ Blood Pressure: \_\_\_\_/\_\_\_\_ (\_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_)

Visual Acuity: Right 20 / \_\_\_\_ Left 20 / \_\_\_\_ Corrected: Yes No Pupils: Equal \_\_\_\_\_ Unequal: \_\_\_\_\_

FINDINGS	NORMAL	ABNORMAL FINDINGS	INITIALS*
<b>MEDICAL</b>			
1. Appearance	_____	_____	_____
2. Eyes/Ears/Nose/Throat	_____	_____	_____
3. Lymph Nodes	_____	_____	_____
4. Heart	_____	_____	_____
5. Pulses	_____	_____	_____
6. Lungs	_____	_____	_____
7. Abdomen	_____	_____	_____
8. Skin	_____	_____	_____
<b>MUSCULOSKELETAL</b>			
9. Neck	_____	_____	_____
10. Back	_____	_____	_____
11. Shoulder/Arm	_____	_____	_____
12. Elbow/Forearm	_____	_____	_____
13. Wrist/Hand	_____	_____	_____
14. Hip/Thigh	_____	_____	_____
15. Knee	_____	_____	_____
16. Leg/Ankle	_____	_____	_____
17. Foot	_____	_____	_____

\* - Station-based examination only

**ASSESSMENT**

\_\_\_\_\_ Cleared without limitation.

\_\_\_\_\_ Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_

\_\_\_\_\_ Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_

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

Name of Physician (print or type): \_\_\_\_\_ Date: \_\_\_\_\_

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

Signature of Physician: \_\_\_\_\_, MD or DO

*Based on recommendations developed by the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine and American Osteopathic Academy for Sports Medicine.*