

CFNL

CHARACTER FOOTBALL LEAGUE

UNION BAPTIST CHURCH-DR. SIR WALTER MACK, JR., PASTOR AND TEACHER

2010 PARTICIPANT CONTRACT AND PARENTAL CONSENT FORM

Special Note: This form is applicable only for the 2010 season. In addition to this form, the following items must be submitted in order for your child to participate: Physical Form Completed by a Physician; Copy of Birth Certificate, Copy of Last Report Card/Progress Report

Sport: Football_____ Cheerleading_____ Drum Line_____

Your Team Last Year _____ Did Not Participate Last Year _____

Legal Name of Participant (must match birth certificate)

Last _____ First _____ Middle _____

Male ___ Female _____ Nickname _____

Birth date _____ Age _____ Age as of August 31st _____

Weight _____ Height _____ Chest _____

School: _____ Current Grade _____

What Are Your Report Card Grades? _____ What is Your Conduct? _____

What Subjects do you need help with the most? _____

T Shirt Size: Youth: Small ___ Medium ___ Large ___ XL ___

Adult: Small ___ Medium ___ Large ___ XL ___ 2XL ___ 3XL ___ 4XL ___

(Cheerleaders Only) Shoe Size _____

Name of Parent/Guardian _____

Relationship to Athlete: _____

Address _____

City _____ State _____ Zipcode _____

Telephone: Home: _____ Mobile: _____ Work: _____

E-Mail Address _____

Best Phone Number to reach you in case a practice/game is cancelled an hour before scheduled time: _____

Are you a member of Union Baptist Church _____ If not, what church? _____

Emergency Contact Information (if the parent/guardian can not be reached)

Name _____
Relationship to Student _____
Home No: _____ Mobile: _____ Work: _____

Please read and sign:

Acknowledgement of Risk of Injury/Release and Waiver - I acknowledge and understand that there may be a risk of injury involved in the activities, which my child will engage in during the program. In consideration of Union Baptist Church allowing my child to participate in the program and various field trips which may be taken from time to time, I hereby agree to release, waive, discharge, covenant not use, hold harmless and indemnify, on behalf of respective officials, agents, employees, directors, members, officers and other staff members from liability to us and our child, as well as our personal representatives, assigns, heirs and next of kin, for any and all claims, suits or causes of action from or out of any injury, known or unknown, to property or body, that my child may suffer from participation in Union Baptist Character Football League activities, field trips or the above described Program; and do hereby expressly assume the risk of injury associated with participation in said Program.

Certification of Ability to Participate and Medical Authorization. I, the undersigned, hereby certify that to the best of my knowledge my child is able to safely participate in the Program activities for which he or she as been registered. I, the undersigned, understand that in case of illness or injury of my child Union Baptist Church staff will try to notify me or the emergency contact listed on the Program application form. In the event of a medical emergency concerning my child at a time when either I or the emergency contact person cannot be notified, I hereby authorize Union Baptist Church staff or my child's caregiver, as applicable, to obtain necessary medical care and/or treatment, including but not limited to first aid, X-Ray, examinations, and aesthetic, medical or surgical diagnosis or treatment or hospital care and I hereby accept the sole financial responsibility for such medical care, first aid or treatment.

Hospital Preference _____

Accident Insurance- Participants are responsible for their own accident insurance when participating in Union Baptist Church programs.

Blood Borne Pathogen Exposure- I understand that, while my child is in the care of Union Baptist Church, if a child is exposed to a body fluid or broken skin or mucous membrane, from another child, a Union Baptist Church Staff member will contact the parents of both children. They will explain what has occurred, and then provide the name of the attending physician of the source child to the parents of the exposed child. If a staff member has a blood or body fluid exposure from a child, Union Baptist Church will provide the name and telephone number of the child's attending physician to the staff member. I have read and agree with the statement and specifically authorize Union Baptist Church to release the name and telephone number of my child's physician, and a description of the event to the parent or guardian of any child who is exposed to blood or body fluid or any staff member who experiences such exposure from my child.

Photographs - Photographs will occasionally be taken of the children during the Program. I, the undersigned, consent to the use of pictures of my child for displays, brochures and promotional materials with no compensation to my child or me.

I, the undersigned, have read this release and understand all of its terms. I execute it voluntarily and with full knowledge of its meaning and significance.

Parent Signature: _____ **Date:** _____

Print Parent/Guardian Name: _____

Amount Submitted: _____ **\$100 By June 1st** _____ **\$150 After June 1st**

Office Use:

Received by: _____ **Date:** _____

Forms Received: *Physical Form* _____ *Birth Certificate* _____ *Progress Report* _____

Cash/Check: \$ _____ **Check #** _____ **Notes:** _____

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2010 PHYSICAL FITNESS & MEDICAL HISTORY FORM

Special Note: No other forms are acceptable unless Section II is modified or substituted ONLY to comply with local/or state laws or because of medical practitioner regulations (i.e. the medical practice insists on its own form). In either case, Section I must still be filled out entirely and attached to the modified/substituted form. Section II must be completed in its entirety ONLY by a Licensed State Examiner (medical doctor, nurse practitioner, etc.)

Section I: *FOR PARENT/GUARDIAN COMPLETION ONLY*

Legal Name of Participant (must match birth certificate):

Last _____ First _____ Middle _____

Address _____

City _____ State _____ Zip _____

Telephone No: _____ Mobile No: _____

Date of Birth _____ Male _____ Female _____

Name of Primary Medical Insurance _____

Policy Number _____ Membership Number _____

Name of Primary Insured: _____

Sport (*check one*): Cheerleading _____ Dance _____ Tackle _____ Flag _____

Drum Line _____

PARTICIPANT MEDICAL HISTORY

1. Are there any injuries requiring medical attention? Yes ___ No ___
2. Are there any past surgeries or scheduled surgeries? Yes ___ No ___
3. Is the participant currently under the care of a medical practitioner? Yes ___ No ___
4. Is the participant currently taking any medications? Yes ___ No ___
5. Does the participant have any allergies? (Penicillin, bee sting, etc) Yes ___ No ___
6. Does the participant have asthma/require the use of an inhaler? Yes ___ No ___
7. Is the participant diabetic/require medication for diabetes? Yes ___ No ___
8. Does the participant currently require medication? Yes ___ No ___
9. Does/has the participant have/had seizures? Yes ___ No ___
10. Does the participant wear glasses or contact lenses? Yes ___ No ___
11. Does the participant wear a brace or other medical support device? Yes ___ No ___
12. Does the participant have any other physical limitations or medical conditions? Yes ___ No ___

If you answered yes to any of the above questions, please provide the question number and an explanation in the following space: _____

I hereby certify that this information is accurate to the best of my knowledge. I understand that this medical authorization may be voided in the event of injury, illness or accident and my child may not be cleared for participation at such time. Furthermore, I hereby acknowledge that it is my responsibility to inform my child's coach or organization official in writing if there is any change in the medical condition of my child. I also understand that it's my responsibility to obtain written permission from my child's physician on official medical stationary in order to seek permission for my child to resume participation after any and all such injury, illness or accident.

Signature of Parent or Legal Guardian: _____

Print Name: _____

Relationship to Participant: _____

Dated: _____

Character Football League

Section II: **THIS SECTION IS TO BE COMPLETED BY A MEDICAL PROFESSIONAL**

Name of Participant: _____

(Please check the following if healthy or note otherwise)

Height Weight Eyes
Ears Mouth Nose Throat
Respiratory Cardiovascular Neurological
Muskoskeletal Dermatological Blood Pressure

I hereby certify that I am a licensed state examiner and have examined the above named individual and understand that he/she will be involved in participating in Character Football League. I hereby swear and attest that this individual is physically fit and I have found no medical reason which would prevent this individual from safely participating in Character Football League activities for the 2009 season. I am therefore clearing this individual for athletic participation without limitation.

Please place medical professional stamp here or fill out the following:

Signed _____ Date _____

Print Name: _____

Please indicate medical profession (M.D., D.O., RN, etc.) _____

Complete this section or the medical professional's stamp may be placed below.

Address _____

Telephone Number _____/Fax Number _____

Section II must be completed in its entirety ONLY by a Licensed State Examiner (medical doctor, nurse practitioner, etc,-this may vary by state.) No other forms are acceptable unless Section II is modified or substituted ONLY to comply with local and/ or state laws or because of medical practitioner regulations (i.e. the medical practice insists on its own form). In either case, Section I must still be filled out entirely and attached to the modified/ substituted form.