



ST. VINCENT DE PAUL COLLEGE PREP

ATHLETIC CLEARANCE PACKET & PAYMENT FORM

ATHLETE NAME: _____

This Packet must be completed and turned in **PRIOR** to participation in any sport. PLEASE NOTE: [The SVdPHS Inc. Student-Athlete Health Information form](#) must be completed and signed by a licensed physician prior to **ANY** participation including practice.

WE RECOMMEND PARENTS TO GET THE PHYSICALS DONE PRIOR TO THE BEGINNING OF SCHOOL. MUST BE DATED AFTER JULY 1.

NOTE: When Athletic Clearance Packets are submitted the students will be billed to the student's FACTS account.

ATHLETIC PARTICIPATION CLEARANCE:

Have you attended any other High School other than SVdPHS? Yes _____ No _____
**** If the answer is yes please also fill out an NCS transfer form** found on the NCS website www.cifncs.org.

STUDENT ATHLETE QUESTIONNAIRE:

Name of Previous school: _____ GPA: _____

PARENTAL PERMISSION: I/we consent that

_____ has permission to
PLEASE PRINT STUDENT FIRST AND LAST NAME

Participate in the following sports: (Please check whatever sports apply)

\$350 fee for each of the following sports

_____ Football

\$300 fee for each of the following sports

_____ Lacrosse (mens and womens)

_____ Basketball (mens and womens)

\$250 fee for the following sports

_____ Baseball

_____ Golf (mens and Womens)

_____ Soccer (women's)

_____ Softball

_____ Tennis (men's and women's)

_____ Volleyball

_____ Wrestling

\$150

_____ Cheerleading

I UNDERSTAND THAT I WILL NOT BE ALLOWED TO PLAY A SPORT IF FEES ARE NOT PAID (please reach out to the athletic director if a payment plan is necessary)

STUDENT ATHLETE CONTRACT:

We the undersigned, student athlete and parent(s)/guardian(s) acknowledge that we have read and understand the policies set forth by St. Vincent de Paul College Prep High School Inc. in the **STUDENT/PARENT HANDBOOK**. (handbook available on the school website) svhs-pet.org

Parent/Guardian Signature: _____ Date: _____

Student Athlete Signature: _____ Date: _____

PERMISSION TO TRAVEL:

If you have restrictions as to whom your child may ride with please check NO and stipulate the name of the parent whom your child may ride with. If any team parent or coordinated bus transportation may transport your child please check YES.

____ YES _____ NO If no please indicate the names of parents your student may travel with below:

I give permission for my student athlete _____ to travel on any bus transportation coordinated for games and/or any parent that has been approved to drive.

Parent/guardian Signature: _____ Date: _____

**** PLEASE NOTE THAT ALL ATHLETES MUST TRAVEL WITH THEIR TEAMS TO THE GAMES/CONTESTS. IF A PARENT OF A STUDENT ATHLETE BECOMES A DRIVER AFTER A GAME/CONTEST THE STUDENT ATHLETE MUST INFORM THE COACH OF THE CHANGE**

ACKNOWLEDGEMENTS:

The St. Vincent de Paul College Prep High School Inc. Athletic department has made every effort to clarify all policies regarding participation in school sports. Please feel free to contact the school anytime if you have questions. Please initial and sign the appropriate areas below. These signatures indicate that all policies and procedures are understood and will be adhered to by parents and student athletes.

_____ 1. I have read and understand the SVdPHSInc. Athletic Policies (found in the Student/Parent handbook)

_____ 2. I have read the Parental Permission to travel. (included above)

_____ 3. I have read the Drug and Alcohol Policy (Included in the Student/Parent Handbook)

_____ 4. I have read the early dismissal policy. (Included in the Student/Parent Handbook)

_____ 5. I have read the North Coast Section Ejection Policy (Link Attached below please read sign and return to the Director of Athletics)

_____ 6. I have read the reminders on Parental Behavior(Included in the Student/Parent Handbook)

_____ 7. I have read the reminders about Athletic Sportsmanship.(Included in the Student/Parent Handbook)

_____ 8. I have read the Concussion Information Sheet. (Link attached below, KEEP FOR YOUR RECORDS)

_____ 9. I have read the Sudden cardiac Arrest Information. (Link attached below. KEEP FOR YOUR RECORDS)

_____ 10. I have read the Football helmet warning Statement (Football Only)

Parent/Guardian Signature: _____ Date: _____

Print Parent/Guardian Name: _____

<https://drive.google.com/file/d/13msiKYulSg5i8igOWPVi7MbNuEWzi2Sx/view?usp=sharing>

Health Inventory

Dear Parent(s):

In order to provide the best educational program for your child, the school would appreciate you providing the following health information. Please check which of the following conditions your child has/had, and give his/her age at the time of illness and whether he/she is still under care of a physician for this condition.

CONDITION	CHECK IF YES	APPROX AGE	UNDER PHYSICIAN CARE
Allergies (Bee, hay fever, food, other)			
Asthma			
Heart Condition			
Diabetes			
Kidney Disease			
Epilepsy: Petit Mal ___ Grand Mal ___			
Frequent/ Severe Headaches			
Fainting			
Speech			
Hearing			
Vision			

Has the athlete been diagnosed with a concussion? _____ NO _____ If yes, how many? _____

Is physical activity limited? Yes _____ No _____

If yes , is there a Physician's Statement on file with the school? Yes _____ No _____

Does your child have any condition which could be a school emergency? Yes _____ NO _____

If yes please explain: _____

Is your child taking any medication prescribed by a physician?

Please list: _____

B/P: _____ Height: _____ Weight: _____

Please list below or on the back of this page **any significant health problems that might be significant to a physician evaluating your child in case of an emergency:**

DOCTOR CERTIFICATION

Athlete's Last Name: _____

**Doctors Certification: MUST BE DATED AFTER JULY 1.
(Chiropractic physicals are not accepted)**

This certifies that the above named student is physically able to participate in all interscholastic athletics during the coming school year, except for those listed below:

Exceptions:

DR STAMP FOR VERIFICATION:

Physicians Name: _____ **Phone:** _____

Physicians Signature: _____ **Date:** _____

Consent to Treat:

I _____ parent guardian of student _____ Give consent to authorized St. Vincent de Paul College Prep High School Inc. employee to give permission for necessary medical treatment as authorized by a physician.

Parent Signature: _____

Date: _____

