PRINT FAMILY LAST NAME_____

OUR LADY OF GRACE SCHOOL

EXTRA-CURRICULAR SPORTS APPLICATION

Please mark the appropriate sport

WINTER SEASON

Boys JV/Varsity	☐	Basketball	$70.00
Girls JV/Varsity	☐	Soccer	$70.00
PeeWee	☐	Soccer	$65.00

Application Deadline
Wednesday November 15, 2017

_____ _____ _____

PLAYER'S NAME (please print) GRADE M/F

_____ _____

STREET ADDRESS CITY/STATE/ZIP E-MAIL ADDRESS PLEASE PRINT)

_____ _____ _____

HOME PHONE NUMBER CELL PHONE (MOM) CELL PHONE (DAD)

I/We, the parents/guardians of the above named applicant for a position on the sport selected above, hereby give my/our approval to participate in any and all activities related to the above referenced sport. I/We assume all risks and hazards incidental to such participation including transportation to and from the activities. I/We do hereby waive, release, absolve, indemnify and agree to hold harmless Our Lady of Grace School, Our Lady of Grace Parish, the organizers, sponsors, supervisors, coaches, participants and persons transporting my/our child to and from activities, for any claim arising out of an injury to my/our child, whether the result of negligence or for any other cause, except to the extent and in the amount covered by accident liability insurance.

_____ _____

Father/Guardian Signature Date signed

Or

_____ _____

Mother/Guardian Signature Date signed

A team parent and coach are needed for each team sport. Parent(s) interested in being a team parent or coach, please sign on the designated line below.

I VOLUNTEER TO BE A COACH Name _____

I VOLUNTEER TO BE A TEAM PARENT Name_____

DO NOT SEND PAYMENT WITH THIS FORM

By signing below, I authorize Our Lady of Grace Catholic School to apply the charges above to my FACTS Incidentals Account, and I understand the charges will be invoiced according to the FACTS Incidentals Billing Schedule. I further understand that the ability to apply charges to my FACTS Incidentals Account is contingent upon the Auto Pay Feature being activated. I authorize OLG to activate the Auto Pay Feature on my FACTS Incidentals Account for these charges and I understand that these charges will be automatically deducted from my financial account on the invoice due date unless the charges have been paid in full directly to FACTS at least three business days prior to the invoice due date.

_____ _____

Signature Date

OUR LADY OF GRACE SCHOOL

MEDICAL RELEASE FORM FOR EXTRA-CURRICULAR SPORT PLAY

_____ _____ _____

LAST NAME, FIRST NAME OF CHILD GRADE DATE

I, the undersigned, parent/guardian of the above named child have contacted and received permission to authorize:

1. _____ _____ _____ _____
   Name - (Relative/friend) Address Mobile # Home #
2. _____ _____ _____ _____
   Name - (Relative/friend) Address Mobile # Home #
3. _____ _____ _____ _____
   Name - (Coach) Address Mobile # Home #

as agent/s for the undersigned, to consent to any x-ray examination, anesthetic, dental, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician or surgeon licensed under the provisions of the State Medical Practice Act, whether such examination, diagnosis or treatment is rendered at the office of said physician or at a hospital.

Authorization is given in advance of any specific examination, diagnosis, treatment or hospital care required. I give power on the part of my aforesaid agent/s to give specific consent to any and all such examinations, diagnosis, treatment that may be deemed advisable. The undersigned hereby assumes all financial responsibility for the obligations incurred by said agent/s on behalf of said minor. It is understood that, if medical attention is needed, the parent be notified immediately, if possible.

Students participating in extracurricular sports are <u>required</u> to have medical insurance coverage before playing a sport. It is <u>essential</u> that parents assume the responsibility of obtaining this medical insurance.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil code of California.

This authorization shall remain effective until _____.

Is child on medication? _____ If so, what?_____

Please list allergies_____

WRITTEN SIGNATURE ONLY:

Parent/Guardian_____

Address_____

Home phone_____

Cell phone_____

Emergency Hospital preferred_____

Primary Insurance Carrier_____

Group Number_____

FAMILY DOCTOR

Name_____

Address_____

Phone_____

DENTIST

Name_____

Address_____

Phone_____