

# St. Francis Sports Performance Challenge

Thank you for participating in St. Francis Sports Performance Challenge! Enclosed in this packet are forms to complete before the event on Mar. 20. Please bring the completed forms with you to the event.

## **This packet includes:**

- Registration form
- Medical history form
- Parental waiver – If your parent does not accompany you to the event, please have your parent complete the form and bring it with you to the event. This form **must** be completed by your parent in order for you to participate. **No exceptions!**

## **Instructions for Day of the Event:**

- Bring completed registration form, medical history form and parental waiver form.
- Wear molded cleats or turf shoes. **NO METAL CLEATS.**
- Be on time. You should arrive approximately 15 minutes before your scheduled start time. Late arrivers may be asked to reschedule.
- Do your best.
- Have a good time!



BON SECOURS  
ST. FRANCIS HEALTH SYSTEM

## St. Francis Sports Performance Challenge Registration Form

Participant's Name \_\_\_\_\_

Age \_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell # \_\_\_\_\_ Parent/Guardian# \_\_\_\_\_

E-mail \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Phone Number where this person can be reached during this event: \_\_\_\_\_

Relationship to participant: \_\_\_\_\_

How did you hear about the event? School \_\_\_\_ Ad \_\_\_\_ Friend (name) \_\_\_\_\_

Other: \_\_\_\_\_

What sport do you play / what position? \_\_\_\_\_

What school do you attend? \_\_\_\_\_

Coach's Name: \_\_\_\_\_ Team Name: \_\_\_\_\_

Current Grade: \_\_\_\_7<sup>th</sup> \_\_\_\_8<sup>th</sup> \_\_\_\_9<sup>th</sup> \_\_\_\_10<sup>th</sup> \_\_\_\_11<sup>th</sup> \_\_\_\_12<sup>th</sup>

T-shirt size: \_\_\_\_M \_\_\_\_L \_\_\_\_XL \_\_\_\_2X

## St. Francis Sports Performance Challenge Medical History Form

Name \_\_\_\_\_ DOB \_\_\_\_\_

Phone # \_\_\_\_\_ Cell # \_\_\_\_\_

Grade \_\_\_\_\_ Sport(s) \_\_\_\_\_

Address \_\_\_\_\_

Mother \_\_\_\_\_ Work # \_\_\_\_\_

Home # \_\_\_\_\_ E-mail \_\_\_\_\_

Father \_\_\_\_\_ Work # \_\_\_\_\_

Home # \_\_\_\_\_ E-mail \_\_\_\_\_

Insurance Carrier \_\_\_\_\_

**Emergency Contact** \_\_\_\_\_

	Name	Relation to Student
<b>Phone #'s</b>	_____	_____

Yes/ No Do you have any of the following? (check appropriate box and list details)

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Medical Alert Allergies _____                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergic to any medication(s) _____              |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin or food allergies _____                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma _____ Do you have an Inhaler? _____       |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Condition/murmur _____                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Vision loss _____                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy _____                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes _____                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney condition _____                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing loss _____                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Severe/frequent headaches _____                  |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure _____                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Infectious mononucleosis (mono) _____            |
| <input type="checkbox"/> | <input type="checkbox"/> | Acquired Immune deficiency syndrome (AIDS) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid Arthritis _____                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Osgood-Schlatter's disease of the knee _____     |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____                                      |

Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling of any bones or joints?

_____ Head	_____ Shoulder	_____ Thigh	_____ Neck	_____ Elbow
_____ Knee	_____ Chest	_____ Forearm	_____ Shin/Calf	_____ Foot
_____ Ankle	_____ Hip	_____ Hand	_____ Wrist	_____ Back

Yes/  No History of blacking out/head injury (check appropriate box and list details)

- Do you ever become dizzy during exercise? \_\_\_\_\_
- Do you ever experience chest pain during exercise? \_\_\_\_\_
- Has anyone in your family died of heart problems before the age of 50? \_\_\_\_\_
- Have you ever been knocked unconscious? \_\_\_\_\_
- Have you ever passed out from the heat? \_\_\_\_\_
- Have you ever blacked out while exercising? \_\_\_\_\_
- Do you have trouble breathing during exercise? \_\_\_\_\_
- Do you cough during or after strenuous activities? \_\_\_\_\_
- Do you have nosebleeds? \_\_\_\_\_

**Additional medical information:**

Previous injuries/surgeries (month/year)? \_\_\_\_\_

Date of last tetanus booster: \_\_\_\_\_

Have you had a physical in the past year?  yes  no

Have you been advised to restrict activity in the past (5) years?  yes  no

Please explain: \_\_\_\_\_

Are you on any medication that is taken on a regular basis? (List) \_\_\_\_\_

Does your family have a primary care physician? (Name/ phone#)

\_\_\_\_\_

Does your family have an orthopedic MD? (Name/phone#)

\_\_\_\_\_

My child may take any over-the-counter medication such as Tylenol®/Advil®  yes  no  
Specific \_\_\_\_\_

**Any other pertinent medical history:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby state that, to the best of my knowledge, I have given a correct and accurate medical history report.

**Athlete's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



**D1 and St. Francis Parental Waiver  
D1 Sports Training and Therapy of Greenville**

1334 Miller Road  
Greenville, SC 39607  
864.288.3868

Participant's Name \_\_\_\_\_

**PLEASE READ THE FOLLOWING CAREFULLY:** D1 Sports Training of Greenville, LLC ("D1") and Bon Secours St. Francis Health System undertake the responsibility to provide your child (a "Participant") with sports training and other sports-related services (the "Program"). By signing below, you acknowledge that you agree to the following terms:

You represent that Participant is physically and mentally fit to participate in the Program and that, prior to participation in the Program, you have consulted Participant's physician regarding any limitations or medical risks that Participant may have in relation to the Program and certify that Participant is free from any such limitations or medical risks. You further agree that sports training, physical exertion and the Program involve certain risks and serious bodily injury and death may occur to Participant. With full knowledge of the potential for the risk of bodily injury to Participant, you voluntarily choose to allow Participant to take part in the Program and hereby release and waive all liability on behalf of D1 and St. Francis Hospital, and their employees, executives, agents and contractors for any bodily injury of any kind suffered by Participant as a result of taking part in the Program, regardless of whether such injury or death was due to negligence (of any kind) on the part of D1 or St. Francis Hospital.

To market, advertise and promote the Program and D1 and St. Francis Hospital, we may take photographs and record video of Participant during the Program. You hereby consent to the taking of such photographs and video and waive your right or Participant's right to any claim of ownership or compensation for Participant's appearance in such photographs or video.

I understand that this liability waiver is intended to be as broad and inclusive as permitted by the laws of the state of Tennessee and agree that if any portion is held to be invalid, the remainder will continue in full legal force and effect. I further agree that any legal proceedings related to this waiver will take place in Nashville, Tennessee. I represent that I am a parent/legal guardian of the child named above and I agree that the terms of this release are binding on me and the Participant.

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Relation to Participant:    Parent    Legal Guardian