ATHLETIC / PHYSICAL REGISTRATION FORM

STUDENT INFORMATION

NAME:	GENDER:	GRADE:	BIRTHDAY:
ADDRESS:	CITY:		ZIP:

PARENT/GUARDIAN INFORMATION

FATHER:	CELL:	EMAIL:
MOTHER:	CELL:	EMAIL:

REQUIREMENTS FOR STUDENT-ATHLETE'S ELIGIBILITY

1.Signed Registration Form 2. Good academic & behavioral standing 3. Primary Insurance covering the athlete

INSURANCE POLICY

Archimedean Schools' Board, Miami-Dade County Public Schools and the State of Florida require that the parents/guardians of all student-athletes certify that they have medical primary insurance coverage in place for their student-athlete(s) on a family plan. The parent/guardian must cover all expenses in the event of an athletic injury. It must be understood that the Archimedean Schools' Board, the Athletic Department of Archimedean Schools, the Archimedean Middle Conservatory, and the Archimedean Community Center assume no direct or implied responsibilities for expenses resulting from any athletic injury.

PARENT/GUARDIAN PRIMARY INSURANCE THAT INCLUDES THE STUDENT-ATHLETE

INSURANCE COMPANY NAME:

POLICY NUMBER:

COMPETITIVE TEAM PARTICIPATION GENERAL POLICY

In order for the athletic program to maintain competitive athletic teams, parents/guardians of the student-athletes that are selected during try-outs to participate in the AMC athletic teams, are required to contribute to the expenses of the program as they are set by the school's Administration. The contribution towards the expenses of the athletic team is non-refundable and non-transferable to other teams.

PARENT/GUARDIAN CONSENT

I have read, understand and agree with the insurance and the participation policy that Archimedean Upper Conservatory requires. By signing below I certify that all information I have written on this document are correct and I give my consent for _____ (student name) to participate in the athletic program of the Archimedean Middle Conservatory and to be transported by buses, when needed, to and from athletic competitions. I give permission to the Archimedean Athletics' Staff to take whatever emergency measures are deemed necessary for the care and protection of my child while under their supervision. In case of a medical emergency, I understand that my child will be transported to an appropriate medical facility by the local emergency unit for treatment if the local emergency team deems it necessary. It is understood that in some medical situations the Archimedean Athletics' Staff will need to contact the local emergency resources before the parent/guardian. Finally, I agree to contribute to the expenses of the program as they are set by the school.

Parent/Guardian Signature:_____ Date:_____

Parent/Guardian Print name:_____

PRE-PARTICIPATION PHYSICAL EVALUATION

Physical Examination: to be completed by licensed physician, licensed osteopathic physician, licensed chiropractic physician, licensed physician assistant or certified advanced registered nurse practitioner.

Student's Name : _____ Date of Birth: _____

Height: _____ Weight: _____ Pulse: _____ Blood Pressure: _____

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

ASSESSMENT OF EXAMINATION

I hereby certify that each examination listed above was performed by myself or an individual under my direct supervision with the following conclusion(s):

_____ Cleared without limitations

_____ Disability: _____ Diagnosis: _____

_____ Precautions: _____

_____ Not Cleared for: _____ Reason: _____

_____ Cleared after completing evaluation/rehabilitation for: _____

_____ Referred to: _____ For: _____

Recommendations: _____

Name of Physician/Physician Assistant/Nurse Practitioner (print) _____

Address: _____

Signature: _____ **Date:** _____

MEDICAL HISTORY

List / describe below any medical concerns that your child had in the past and we should know about.

_____

_____

_____

_____

_____

_____

_____

EMERGENCY CONTACT - PEOPLE AUTHORIZED TO PICK UP THE STUDENT - ATHLETE

1. Name: _____ Relationship: _____ Cell: _____

1. Name: _____ Relationship: _____ Cell: _____

1. Name: _____ Relationship: _____ Cell: _____

Parent / Guardian signature: _____ Date: _____

Parent / Guardian print name: _____ Date: _____

Please click the icon below to open the Credit Card Authorization form

Credit Card
Authorization Form

Please be informed that the recurring fee for participating in AMC Athletics is $120 per month.