

2017-2018 NDAA ATHLETIC REGISTRATION – Grades 5 - 8

Please print CLEARLY. 2017-18 Athletic Fee is \$75. Please see note below regarding payment options.

Athlete's Name _____

Parents/Guardian _____

Email _____

Can the coaches communicate with you via email? (schedule changes, cancellations, etc.) Yes _____ No _____

Is it OK to share your contact information with event chair people? Yes _____ No _____

Phone (home) _____ Mom's Cell(s) _____ Dad's Cell (s) _____

Please check the appropriate lines below. Please choose the grade entering for the 2017-18 school year.

| | | | |
|-------------------------------|-------------------------------------|--|--|
| <input type="checkbox"/> Boy | <input type="checkbox"/> St. Peter | <input type="checkbox"/> 8 th Grade | <input type="checkbox"/> Volleyball (5 th , 6 th , 7 th , 8 th girls) Fall Season |
| <input type="checkbox"/> Girl | <input type="checkbox"/> Holy Ghost | <input type="checkbox"/> 7 th Grade | <input type="checkbox"/> Football (7 th , 8 th boys) Fall Season |
| | <input type="checkbox"/> Notre Dame | <input type="checkbox"/> 6 th Grade | <input type="checkbox"/> Cross Country (5 th , 6 th , 7 th , 8 th girls & boys) Fall Season |
| | | <input type="checkbox"/> 5 th Grade | <input type="checkbox"/> Basketball (5 th , 6 th , 7 th , 8 th girls & boys) Winter Season |
| | | | <input type="checkbox"/> Track (6 th , 7 th , 8 th girls & boys) Spring Season |

Emergency Contact 1 _____ Relationship _____

Home # _____ Work # _____ Cell # _____

Emergency Contact 2 _____ Relationship _____

Home # _____ Work # _____ Cell # _____

Insurance company _____ Policy # _____

Parent Employer (for insurance) _____

Physicians Name _____ Phone _____

Dentists Name _____ Phone _____

Are you allergic to any drugs? _____ If so what _____

Do you have any other allergies/ (i.e. bee sting, Dust) _____

Do you suffer from Asthma _____ Diabetes _____ Epilepsy _____

Are you on any medication _____ If so what? _____

Ever had a head injury? _____ If yes, when _____ Lose Consciousness? _____

Do you wear contacts? _____

Other medical issues _____

I authorize school personnel to transport my son daughter to a physician's office and/or emergency room for treatment in the event medical care is needed while he/she is involved in either co-curricular or extra-curricular activities. Further I authorize the Physician and Hospital staff to treat my son/ daughter, as they deem necessary in an emergency situation. This authorization is granted should I be unable to be reached, and a reasonable effort has been made to do so.

PARENT/ GUARDIAN SIGNATURE _____ Date _____

2017-18 ND Athletic Fee is \$75 per athlete for the year.

Registration payments will be accepted AFTER July 1, 2017.

You may also pay at Welcome Back Wednesday.