Acadian Christian Athletics

Registration - STEP 2 Instruction

Please thoroughly Read, Print, Complete, Sign, and Turn In all of the documents in this folder to ACA before the first day of practice. Also be sure to print a copy of each form for your records.

After completing STEP 2, you will still need to complete Steps 3 & Steps 4 before you will be fully registered.

STEP 3 is to schedule a doctor's appointment and complete a physical. You will need to have your physician fill out the LHSAA Medical Evaluation Form provided in this folder.

STEP 4 is to provide ACA with your most recent Academic Transcript OR for Tennis - provide an updated birth certificate.

If you did not pay in full during Step 1, you can make payment(s) online - https://acadefenders.org/payments/ or in-person via cash or check made out to 'Acadiana Christian Athletics'.

If you have any questions, please visit acadefenders.org/contact and fill out the form or email info@acadefenders.org

Acadiana Christian Athletics Registration

_____
Parent/Guardian Name

_____
Student-Athlete Name

I/We, the parent/guardian, of the below named hereby give my consent to participate in any and all activities conducted by Acadiana Christian Athletics(ACA) at designated practice and game facilities which vary by sport. For example football and cheerleading are conducted at Moore Park, St. Julien Park, Broussard Park, Clark Field. I/We are aware of the risks and hazards inherent with physical activity and exertion.

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 the ACA Organization and/or Board of Directors, Lafayette Parks and Recreation, Moore Park/LYSA, St. Julien Park, The City of Broussard and/or the practice or game facility owners, organization, the organizers, sponsors, supervisors, volunteers, and participants for any claim arising out of an injury to myself and/or my child. This includes any injury or death that may result while transporting myself/my child to and from activities, whether the result of negligence or for any other cause, except to the extent and in the amount covered by accident or liability insurance. As in exposure to any individual or group physical activity there is an inherent risk of injury. Risks of participation in these events are minimal. However, injury can occur and include but are not limited to: abrasions, contusions, lacerations, sprains, strains, fractures, head trauma, heat stroke, myocardial infarct, and sudden death. In general, the inherent risk is less than or equal to what an athlete is exposed to while participating in most sponsored sporting supervised events.

I/We, the parent/guardian consent to the use of video and photographic imaging of ACA activities in while I/my child participates. I/We, the parent/guardian understand that some ACA activities may include video and/or photographic recordings. The images are to be under the exclusive ownership of ACA and are used only for educational and marketing purposes as they relate to ACA. I/We, the parent/guardian understand that there is no compensation for the generated images.

I have been given an opportunity to have any questions answered to my satisfaction. I have read and understand the above.

_____ _____
Parent/Guardian Signature Date

_____ _____
Student-Athlete Signature Date

Acadiana Christian Athletics Registration

Eligibility - in order to participate in the Acadiana Christian Athletics' football team, participants must meet the following requirements.

1) Participant must not turn 19 years of age prior to September 1st.
2) Participant must be home schooled or attend a school that does not offer football. A request for participation may be turned in by athletes not meeting this requirement. Determined in case by case basis.
3) Participant must not have completed all graduation requirements or received a GED.
4) Participant must be in the care of a responsible adult and legal guardian.
5) Participant may not attend college full time, unless part of a joint enrollment program.
6) Joint enrollment students please list all high school courses being taken:_____
_____
7) Participant may not be employed full time (40 hours per week).
8) Participant must maintain compliance with their schools attendance policy or comply with Louisiana regulations for home school students.

Insurance - part of your registration will pay for insurance but this is above and beyond your individual policy. In case of emergency we need the following:

Insurance Company:_____
Name of Insured:_____
Policy #_____ Member #_____
Phone number for insurance company:_____

Non Homeschool Students
Name of school you are attending:_____
How long have you attended this school:_____
What days and hours are you in school:_____

Homeschoolers
How long have you homeschooled:_____
What is your homeschool style (co-op, online, home w/parent)_____

Acadiana Christian Athletics Registration

Parent's Code of Conduct
-Agreement must be signed in conjunction with registration-

1. I hereby pledge to provide support, care and encouragement for my child participating on the Acadiana Christian Athletics football team by following the Parent's Code of Conduct.
2. I will encourage good sportsmanship by demonstrating positive support for all players, coaches, and officials at every game, practice, or other sporting event.
3. I will place the emotional, spiritual, and physical well being of my child ahead of my personal desire to win.
4. I will insist that my child play in a safe and healthy environment.
5. I will require that my child's coaches be trained in the responsibilities of being a high school / middle school sports coach and that the coaches uphold the Coach's Code of Conduct.
6. I will support the coaches and officials working with my child, in order to encourage a positive and enjoyable experience for all.
7. I will remember that the game is for the students - not the adults.
8. I will do my best to make high school / middle school sports fun for my child.
9. I will require my child to treat other players, coaches, fans, and officials with respect regardless of race, sex, creed, color, or ability.
10. I will inform my child's coach should he sustain any potentially serious injuries, associated or not, with his participation.
11. I will volunteer to assist in whatever capacity I am able.
12. Parents should be aware of the NCAA eligibility requirements so if the player is recruited to play college football there will be no problem in providing the meeting of those eligibility requirements.
13. If a situation arises where I/we have a disagreement with a coach, board member, or another person a part of Acadiana Christian Athletics program I will first go to that person directly after 24 hours and properly communicating a meeting time/date with that person. I/we will handle the situation according to Matthew 18.

I fully support and understand that Acadiana Christian Athletics, INC. is a ministry organization.

All board members and Coaches desire to minister to me and my teammates through sports. By signing this form I agree to abide by this Code of Conduct.

Signature:_____ Date:_____

Acadiana Christian Athletics Registration

Participant's Code of Conduct
-Agreement must be signed in conjunction with registration-

1. I understand and agree that my education is my first and foremost responsibility and that i must meet the expectations of my parents and my school, and I must do my school work.
2. I will play any position assigned to me and will do my best at all times, using good sportsmanship with no intent to ever harm an opposing player or one of my teammates.
3. I will participate cleanly at all times, in a true sportsmanship-like manner with never any intent to harm a squad member.
4. I will participate in a moment of prayer before practices and games with my coaches and teammates.
5. I will treat my coaches, teammates, parents, officials, and other individuals I may come in contact with, with respect at all times, on and off the field.
6. I will not use drugs, alcohol, or tobacco, on or off the playing field and understand that any violation of this agreement will result in suspension from the program.
7. I understand that football is a team sport and that my attendance is required at all practices, games, and events. I will make a commitment to my coaches and teammates to be in attendance and to notify my coach of, for any reason, I am unable to attend any scheduled event.
8. I will not, in any way, damage or deface any property, buildings or equipment.
9. I will abide by the decisions of the game officials and will not display any unsportsmanlike behavior or gestures.
10. I will act as a gentleman at all times and treat others like I would like to be treated.
11. I will not trash talk, use profanity (aka cuss words).
12. I will inform my head coach of any injuries sustained on or off the field, immediately!
13. I will not spread any rumors or make up stories about others. If I am told something negative
about someone or another team, then I will inform my coaches and find out if it is true.
14. I will honor the mission of Acadiana Christian Athletics and act in a way that honors God.

I fully support and understand that Acadiana Christian Athletics, INC. is a ministry organization.

All board members and Coaches desire to minister to me and my teammates through sports.

By signing this form I agree to abide by this Code of Conduct.
Signature:_____ Date:_____

Student-athlete & Parent/Legal Guardian Concussion Statement
Must be signed and returned to Acadiana Christian Athletics.

Student-Athlete Name: _____

Parent/Legal Guardian Name(s): _____

After reading the information sheet, I am aware of the following information:

Student- Athlete initials-Parent/Legal Guardian initials after each sentence.

A concussion is a brain injury which should be reported to my parents, my coach(es) or a medical professional if one is available_____

A concussion cannot be “seen.” Some symptoms might be present right away. Other symptoms can show up hours or days after an injury_____

I will tell my parents, my coach and/or a medical professional about my injuries and illnesses_____

I will not return to play in a game or practice if a hit to my head or body causes any concussion-related symptoms_____

I will/my child will need written permission from a health care provider* to return to play or practice after a concussion_____

Most concussions take days or weeks to get better. A more serious concussion can last for months or longer_____

After a bump, blow or jolt to the head or body an athlete should receive immediate medical attention if there are any danger signs such as loss of consciousness, repeated vomiting or a headache that gets worse_____

After a concussion, the brain needs time to heal. I understand that I am/my child is much more likely to have another concussion or more serious brain injury if return to play or practice occurs before the concussion symptoms go away_____
Sometimes repeat concussion can cause serious and long-lasting problems and even death_____

I have read the concussion symptoms on the Concussion Information Sheet_____

* Health care provider means a Louisiana licensed medical doctor, osteopathic physician or a clinical neuropsychologist with concussion training*

_____ _____
Signature of Student-Athlete Date

_____ _____
Signature of Parent/Legal guardian Date

Acadiana Christian Athletics Registration

General Medical Release

Applicant Name:_____

The medications listed below are over-the-counter (OTC) medications that may be carried by the Acadiana Christian Athletics' Staff.

Please check next to each to confirm that they may be given as indicated:

Triple Antibiotic Ointment as needed for minor wounds__
Hydrocortisone Cream as needed for skin irritation__
Ibuprofen 200 mg 1 or 3 tablets every 6 hours as needed for pain or fever__
Icy/Hot (muscle rub) – Menthol 2.5% as needed for muscle aches__
Antacid Tablets 1 or 2 tablets every 4 hours as needed for leg cramps, heartburn, indigestion__
Benadryl 1 or 2 tablets as needed for allergic reaction__
Allergy Topical Ointment as needed for insect bites__
Salt tabs for cramping__

List any allergies:
_____

List any medical conditions and explain:
_____
_____

I give my consent to the administration of over-the-counter (OTC) medication to my minor child as indicated above. I also give my consent for Acadiana Christian Athletics, Inc. (ACA) board members, coaches and athletic trainers, if I am not present during any ACA sponsored event, to make the necessary decisions for my child's medical care, to include calling 911 and/or any other treatment deemed necessary to care for my child.

_____ _____
Parent/Guardian Signature Date Signed

_____
Printed Name

LHSAA MEDICAL HISTORY EVALUATION

IMPORTANT: This form must be completed *annually*, kept on file with the school, and is subject to inspection by the Rules Compliance Team.

Please Print

Name:_____School:_____Grade:_____Date:_____
Sport(s):_____Sex: M / F Date of Birth:_____Age:_____Cell Phone:_____
Home Address:_____City:_____State:____ Zip Code:_____Home Phone:_____
Parent / Guardian:_____ _Employer:_____ ____Work Phone:_____

FAMILY MEDICAL HISTORY: Has any member of your family under age 50 had these conditions?

Yes	No	Condition	Whom	Yes	No	Condition	Whom	Yes	No	Condition	Whom
☐	☐	Heart Attack/Disease	_____	☐	☐	Sudden Death	_____	☐	☐	Arthritis	_____
☐	☐	Stroke	_____	☐	☐	High Blood Pressure	_____	☐	☐	Kidney Disease	_____
☐	☐	Diabetes	_____	☐	☐	Sickle Cell Trait/Anemia	_____	☐	☐	Epilepsy	_____

ATHLETE ORTHOPAEDIC HISTORY: Has the athlete had any of the following injuries?

Yes	No	Condition	Date	Yes	No	Condition	Date	Yes	No	Condition	Date
☐	☐	Head Injury / Concussion	_____	☐	☐	Neck Injury / Stinger	_____	☐	☐	Shoulder L / R	_____
☐	☐	Elbow L / R	_____	☐	☐	Arm / Wrist / Hand L / R	_____	☐	☐	Back	_____
☐	☐	Hip L / R	_____	☐	☐	Thigh L / R	_____	☐	☐	Knee L / R	_____
☐	☐	Lower Leg L / R	_____	☐	☐	Chronic Shin Splints	_____	☐	☐	Ankle L / R	_____
☐	☐	Foot L / R	_____	☐	☐	Severe Muscle Strain	_____	☐	☐	Pinched Nerve	_____
☐	☐	Chest	_____	Previous Surgeries: _____							

ATHLETE MEDICAL HISTORY: Has the athlete had any of these conditions?

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
☐	☐	Heart Murmur / Chest Pain / Tightness	☐	☐	Asthma / Prescribed Inhaler	☐	☐	Menstrual irregularities: Last Cycle:_____
☐	☐	Seizures	☐	☐	Shortness of breath / Coughing	☐	☐	Rapid weight loss / gain
☐	☐	Kidney Disease	☐	☐	Hernia	☐	☐	Take supplements/vitamins
☐	☐	Irregular Heartbeat	☐	☐	Knocked out / Concussion	☐	☐	Heat related problems
☐	☐	Single Testicle	☐	☐	Heart Disease	☐	☐	Recent Mononucleosi
☐	☐	High Blood Pressure	☐	☐	Diabetes	☐	☐	Enlarged Spleen
☐	☐	Dizzy / Fainting	☐	☐	Liver Disease	☐	☐	Sickle Cell Trait/Anemia
☐	☐	Organ Loss (kidney, spleen, etc)	☐	☐	Tuberculosis	☐	☐	Overnight in hospital
☐	☐	Surgery	☐	☐	Prescribed EPI PEN	☐	☐	Allergies (Food, Drugs)_____
☐	☐	Medications _____						

List Dates for: Last Tetanus Shot:_____ Measles Immunization:_____Meningitis Vaccine: _____

PARENTS' WAIVER FORM

To the best of our knowledge, we have given true & accurate information & hereby grant permission for the physical screening evaluation. We understand the evaluation involves a limited examination and the screening is not intended to nor will it prevent injury or sudden death. We further understand that if the examination is provided without expectation of payment, there shall be no cause of action pursuant to Louisiana R.S. 9:2798 against the team volunteer health-care provider and/or employer under Louisiana law.

This waiver, executed on the date below by the undersigned medical doctor, osteopathic doctor, nurse practitioner or physician's assistant and parent of the student athlete named above, is done so in compliance with Louisiana law with the full understanding that there shall be no cause of action for any loss or damage caused by any act or omission related to the health care services if rendered voluntarily and without expectation of payment herein unless such loss or damage was caused by gross negligence. Additionally,

1. If, in the judgment of a school representative, the named student-athlete needs care or treatment as a result of an injury or sickness, I do hereby request, consent and authorize for such care as may be deemed necessary……....**Yes** **No**
2. I understand that if the medical status of my child changes in any significant manner after his/her physical examination, I will notify his/her principal of the change immediately……..**Yes** **No**
3. I give my permission for the athletic trainer to release information concerning my child's injuries to the head coach/athletic director/principal of his/her school……..**Yes** **No**
4. By my signature below, I am agreeing to allow my child's medical history/exam form and all eligibility forms to be reviewed by the LHSAA or its representative(s) or the associated medical personnel. ……**Yes** **No**

_____ _____ _____
Date Signed by Parent **Signature of Parent** **Typed or Printed Name of Parent**

Health Care Provider section on page 2

IMPORTANT: This form must be completed *annually*, kept on file with the school, and is subject to inspection by the Rules Compliance Team.

Name:_____ Date of Birth:_____ Age:_____ Date:_____
School:_____ Grade:_____Sport(s):_____

II. COMPLETED ANNUALLY BY MEDICAL DOCTOR (MD), OSTEOPATHIC DR. (DO), NURSE PRACTITIONER (APRN) or PHYSICIAN'S ASSISTANT (PA)

Height _____	Weight _____	Blood Pressure_____	Pulse_____

GENERAL MEDICAL EXAM :

	Norm	Abnl
ENT	☐	☐
Lungs	☐	☐
Heart	☐	☐
Abdomen	☐	☐
Skin	☐	☐

ORTHOPAEDIC EXAM :

I. Spine / Neck

	Norm	Abnl
Cervical	☐	☐
Thoracic	☐	☐
Lumbar	☐	☐

II. Upper Extremity

	Norm	Abnl
Shoulder	☐	☐
Elbow	☐	☐
Hand / Fingers	☐	☐
Wrist	☐	☐

III. Lower Extremity

	Norm	Abn
Knee	☐	☐
Hip	☐	☐
Ankle	☐	☐

Health Care Provider notes (if needed):_____

[ ] Medically eligible for all sports without restriction

[ ] Medically eligible for certain sports_____

[ ] Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of _____

[ ] Not medically eligible pending further evaluation

[ ] Not medically eligible for any sports

This recommendation is from a limited screening.

_____	_____	_____
Printed Name of MD, DO, APRN or PA	**Signature of MD, DO, APRN or PA**	**Date of Medical Examination**

Revised 5/23 **This physical expires 13 months from the date it was signed and dated by the MD, DO, APRN or PA.**