

- * Copy of Birth Certificate * Copy of most recent Report Card * Copy of School ID**

COMMUNITY YOUTH ATHLETIC CENTER

PARTICIPANTS INFORMATION

Address _____

City _____ State _____ Zip _____

Home Cell Email

Birthdate _____ Age _____ Gender _____

African-American Asian Hispanic Other

Native American Pacific Islander Caucasian

Name of School	Grade
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Address _____

Office Number _____ Fax _____

[illegible]

Email _____ Cell Phone _____

Employer	Work Phone
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Name	Relationship
John Doe	Uncle
Jane Smith	Sister
Robert Johnson	Father
Emily White	Mother
Michael Brown	Brother
Sarah Green	Sister
David Lee	Father
Lisa Black	Mother
James Wilson	Brother
Amanda Taylor	Sister
Christopher King	Father
Michelle Hall	Mother
Andrew Scott	Brother
Stephanie Adams	Sister
Benjamin Baker	Father
Karen Miller	Mother
Gregory Clark	Brother
Christina Evans	Sister
Anthony Harris	Father
Deborah Young	Mother
Timothy Allen	Brother
Rebecca King	Sister
Jonathan Wright	Father
Kimberly Lopez	Mother
Steven Hill	Brother
Angela Scott	Sister
Patrick Green	Father
Heather Adams	Mother
Timothy Baker	Brother
Christina Miller	Sister
Anthony Clark	Father
Deborah Evans	Mother
Timothy Harris	Brother
Rebecca Young	Sister
Jonathan Allen	Father
Kimberly King	Mother
Steven Wright	Brother
Angela Lopez	Sister
Patrick Hill	Father
Heather Scott	Mother
Timothy Adams	Brother
Christina Baker	Sister
Anthony Miller	Father
Deborah Clark	Mother
Timothy Evans	Brother
Rebecca Harris	Sister
Jonathan Young	Father
Kimberly Allen	Mother
Steven King	Brother
Angela Wright	Sister
Patrick Lopez	Father
Heather Hill	Mother
Timothy Scott	Brother
Christina Adams	Sister
Anthony Baker	Father
Deborah Miller	Mother
Timothy Clark	Brother
Rebecca Evans	Sister
Jonathan Harris	Father
Kimberly Young	Mother
Steven Allen	Brother
Angela King	Sister
Patrick Wright	Father
Heather Lopez	Mother
Timothy Hill	Brother
Christina Scott	Sister
Anthony Adams	Father
Deborah Baker	Mother
Timothy Miller	Brother
Rebecca Clark	Sister
Jonathan Evans	Father
Kimberly Harris	Mother
Steven Young	Brother
Angela Allen	Sister
Patrick King	Father
Heather Wright	Mother
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Christina Hill	Sister
Anthony Scott	Father
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Jonathan Clark	Father
Kimberly Evans	Mother
Steven Harris	Brother
Angela Young	Sister
Patrick Allen	Father
Heather King	Mother
Timothy Wright	Brother
Christina Lopez	Sister
Anthony Hill	Father
Deborah Scott	Mother
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Kimberly Clark	Mother
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Kimberly Lopez	Mother
Steven Hill	Brother
Angela Scott	Sister
Patrick Adams	Father
Heather Baker	Mother
Timothy Miller	Brother
Christina Clark	Sister
Anthony Evans	Father
Deborah Harris	Mother
Timothy Young	Brother

Employer	Work Phone
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Email _____ Cell Phone _____

**CYAC Boxing Program
Release & Wavier Application**

Last Name: _____ **First Name:** _____ **Mi:** _____

Birth Date: _____ **Age:** _____ **Male:** _____ **Female:** _____

Address: _____

City: _____ **Zip:** _____

Telephone: Home () _____ **Work:** () _____

Emergency Contact: _____ **Phone:** _____

Release and Wavier, Assumption of Risk

IN CONSIDERATION OF ME BEING ALLOWED TO PARTICIPATE IN ANY WAY IN CYAC BOXING PROGRAM, ACTIVITIES I AGREE:

- 1.** I understand the nature of the CYAC Boxing Program Activities and my experience and capabilities and believe I am qualified to participate in such activity. I further acknowledge that I am aware the activity will be conducted in facilities open to the public during the activity. I further agree and warrant that if I believe Conditions to be unsafe, I will immediately discontinue further participation in the activity.
- 2.** I fully understand that: (a) the CYAC Boxing Program activities involve risks and dangers of serious and badly injuries, including Permanent Disability, Paralysis and Death (Risks); (b) these risks and dangers may be caused by me or the actions or the inactions of others participating in the activity, the condition in witch the activity takes place, or the negligence of the "releases" named below ;(c) there may be other risks and social and economic losses either known to me or not readily foreseeable at this time; and I fully accept and assume all such risk and all responsibility for losses, costs and damages incurred as a result of my participation in these activities.
- 3.** I hereby release, discharge, covenant not to sue, and agree to indemnify and save harmless the CYAC Boxing Program, their respective administrators, directors, agents, officers volunteers, employers, other participants, any sponsors, owners, and lessors on witch the activity takes place from all liability, claims demands, losses, or damages on my account caused or alleged to be caused a whole or in part by the negligence of the "releases" or otherwise. Including negligent rescue operations and further agree that if despite this release, I , or anyone on my behalf makes acclaim against any of the release above, I will indemnify, save and hold harmless each of these releases from any litigation expenses, attorney fees, loss liability, damage or cost any incur as the result of any such claim.

X _____ **Signature of Applicant** _____ **Date** _____

Parent or Guardian Consent

I am the parent or guardian of the child applying for membership. My child is fit for participation in the CYAC Boxing Program activities, and I consent to my child's participation. I have read and understand the membership application and wavier and release. In consideration of allowing my child to participate, I consent to it any agree that its terms shall likewise bind me, my child, my heirs, legal representatives, and assignees. I hereby release and shall defend, indemnify and hold harmless the releases from every claim and liability that I or my child my allege against the releases (including reasonable attorney's fees or costs) as direct result of injury to me or my child because of my child's participation in the activities or events, whether caused by the negligence of the releases or others. I promise not to sue releases on my behalf or on behalf of my child regarding any claim arising my child's participation in any CYAC Boxing Program Activities.

X _____ **Signature of Parent/Guardian if Participant is under 18** _____ **Date** _____

■ PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.

☐ Medicines

☐ Pollens

☐ Food

☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	Yes	No
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

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■ PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

- Consider additional questions on more sensitive issues
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance supplement?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION			
Height _____	Weight _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	
BP _____ / _____ (_____ / _____)	Pulse _____	Vision R 20/ _____ L 20/ _____	Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS	
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)			
Eyes/ears/nose/throat • Pupils equal • Hearing			
Lymph nodes			
Heart* • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)			
Pulses • Simultaneous femoral and radial pulses			
Lungs			
Abdomen			
Genitourinary (males only) ^b			
Skin • HSV, lesions suggestive of MRSA, tinea corporis			
Neurologic ^c			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
Functional • Duck-walk, single leg hop			

*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
 *Consider GU exam if in private setting. Having third party present is recommended.
 *Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- ☐ Cleared for all sports without restriction
- ☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____
- ☐ Not cleared
- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____
- Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

Physical Examination Signature Page

Attach this page to your athlete passbook (if possible, keep a copy for your records)

Athlete	
Date of Birth:	
Signature:	Date:
Parent/Guardian Signature (if under 18):	

- ☐ Cleared for all sports without restriction
- ☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

- ☐ Not cleared
- ☐ Pending further evaluation
 - ☐ For any sports
 - ☐ For certain sports _____
- Reason _____

Recommendations _____

I have examined the above-named athlete and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

Attach this page to your athlete passbook (if possible, keep a copy for your records)

Community Youth Athletic Center Questionnaire

Name_____

Date_____

1. Do you feel comfortable defending yourself and others? **(Y/N)**
2. Do you feel comfortable speaking giving a presentation? **(Y/N)**
3. Do you trust law enforcement? **(Y/N)**
4. Do you feel that coming to the gym has/will help you in school?
(Y/N)
5. On a scale of 1 to 5, how easy is it for you to make friends?
(1=Difficult, 2=not easy, 3=somewhat easy, 4=easy, 5=very easy)
6. On a scale of 1 to 5, how easy is for you to ask for help?
(1=Difficult, 2=not easy, 3=somewhat easy, 4=easy, 5=very easy)
7. After completing high school, what you see yourself doing?
(College, Trade School, Military, Other).
8. Do you like trying new activities?

SERVICE HOURS Parent Involvement Program

Community Youth Athletic Center (CYAC)



The Parent Involvement Program is a plan where parent's/family members support CYAC through use of their time, talent and treasure. Each family is responsible for completing **40 hours** toward CYAC service in lieu of the membership fee. The hours are to be earned from January 1 through the December 31.

Instructions: Please record the date, activity, Coordinator's Name and number of hours spent in each activity.

Please maintain this form for your own records. You may also submit a copy of this form, along with any signed Service Hour receipts to the CYAC, Attn: Clemente Casillas but please keep a copy for your records. Submittal Deadline for service hours is DECEMBER 30

Family Information – Please Print			
Child's Name		Child's Age	Grade
Parent Name - Last		First	
Home Telephone	Cell Phone	Email	
Date	Event/Activity	Coordinator's Name	Total Time/\$ Donation
Hours Completed Balance of Hours Forwarded <i>(from previous report)</i> Hours Required Hours Remaining			
			40
IMPORTANT PROGRAM NOTES <i>Family or friends may perform hours in your name (must be at least 18 years of age). Hours are credited one for one or \$10 donation for 1 Service Hour.</i>			

YOU MAY ATTACH ALL SERVICE HOUR AND/OR SALES RECEIPTS TO THIS FORM FOR HOURS REPORTED.

"MAKING A DIFFERENCE ONE ROUND AT A TIME"