2025-2026 CCA

Sports Registration Form

Student Information

Name: _____DOB: _____Age _____

Grade in 25-26 School Year: _____
Address: _____
School District You Reside In:_____

Sport you are trying out for:_____
Level (circle one): Middle School (6th-8th grade) / High School (9th-12th grade)

Medical Information

Athlete's Medical Insurance Company_____ Policy #_____

Please check here if your athlete is ***not*** covered under medical insurance _____(we will send a waiver home to you)

Are there any physical limitations and/or problems that should be known by CCA's Coaching Staff and Athletic Trainer? (ex: severe allergy, recent broken bone, concussion, etc.)
_____

Contact Information

Mother/Guardian Name: _____Father/Guardian Name: _____

CCA will use all contact info on file with the school's database for all texts and emails. If you have another email that you'd like to add to our Athletic Emails list, please list it here:_____

I hereby give my permission to have my child taken to a hospital and treated in case of emergency. In consideration of the named student being permitted to participate in the interscholastic sport, we hereby release Calvary Christian Academy and its employees and agents from all liability for any harm, injury or death that the student may suffer while participating in interscholastic sports. We also agree to indemnify and save harmless Calvary Christian Academy and its employees and agents from any and all claims asserted by or on behalf of the named student arising out of participation in interscholastic sports. As well, in accordance with the purpose and spirit of the PIAA by-laws, Article IV, Section 1, I give consent for my son/daughter, a pupil of Calvary Christian Academy, to take part in extracurricular athletic activities in the sport noted above, I state that I have answered the questions about and that, to the best of my knowledge, my answers to the questions are complete and correct. By registering, you agree to be bound by the terms of Calvary Chapel of Philadelphia's Resolution on Participation in Church Activities found at :https://www.ccphilly.org/church-activities-resolution/
If you do not have internet access, you may obtain a copy of the Resolution on Participation in Church Activities from the Church Office.

Parent Signature and Date: _____

2025-2026 CCA Athletics Commitment Contract

Athletes, please read and sign below:

1. I have read the entire Athletic Handbook (found at cca.cphilly.org/athletics), and I understand the philosophy and policies contained in it. I agree to abide by these policies.
2. I understand that joining a team requires a high level of commitment. Therefore, if I am selected to the team, I will not quit before the season is completed. I will also be at all games, practices, and team functions barring illness or injury. If I am going to be absent or late to a practice or game, I will give my coaches advance notice.
3. I understand that being selected for a team is not a guarantee of any set amount of playing time. I agree that the coach has authority to dictate playing time based on his/her evaluation of the team.
4. I understand how important communication with my Coach is. If I have a question or disagreement with my coach, I will discuss it with him/her only. I will do this in private.
5. I understand that being prepared is an important aspect of Athletics. I will make sure to bring my uniform and all necessary equipment for games and practices.
6. I will not neglect my school work due to being a part of a team and understand the Academic Probation rules as outlined in the Athletic Handbook.
7. I will exemplify Christ in my behavior and attitude on and off the field. I will be respectful of coaches, officials, opponents, and other authority figures, as well as uplift and encourage my teammates and opponents.

ATHLETE SIGNATURE:_____

Parents/Guardians, please read and sign below

1. I/We have read the entire Athletic Handbook (found at cca.chilly.org/athletics) and I/We understand the philosophy and policies contained in it. I/We agree to abide by these policies.
2. I/We understand that joining a team requires a high level of commitment. Therefore, if my/our son/daughter is selected to the team, I will not allow him/her to quit before the season is completed. I/We will be timely in picking our son/daughter up from practices and games. If my/ our son/daughter is going to be absent or late for a practice or game, I/we will give the coach advance notice.
3. I/We understand that being selected for a team or payment of an Athletic Fee is not a guarantee of any set amount of playing time. I/We understand that the Coach has authority to dictate playing time based on his/her evaluation of the team.
4. I/We understand how important communication with the Coach is. If I/we have a question or disagreement with the Coach, I/we will respectfully discuss it with the Coach only. I/We will do this in a private setting after scheduling a time with the Coach away from the field/court.
5. I/We understand the Academic Probation rules as outlined in the Athletic Handbook and will support my/our son/daughter in their academics.
6. I/We will be respectful of Coaches, Opponents, Official and Athletic Staff. I/We will cheer in a positive fashion and not degrade the opposition and/or officials.

PARENT/GUARDIAN SIGNATURE:_____

SECTION 7: RE-CERTIFICATION BY PARENT/GUARDIAN

This form must be completed not earlier than six weeks prior to the first Practice day of the sport(s) in the sports season(s) identified herein by the parent/guardian of any student who is seeking to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in all subsequent sport seasons in the same school year. The Principal, or the Principal's designee, of the herein named student's school must review the SUPPLEMENTAL HEALTH HISTORY.

If any SUPPLEMENTAL HEALTH HISTORY questions are either checked yes or circled, the herein named student shall submit a completed Section 8, Re-Certification by Licensed Physician of Medicine or Osteopathic Medicine, to the Principal, or Principal's designee, of the student's school.

SUPPLEMENTAL HEALTH HISTORY

Student's Name _____ Male/Female (circle one)

Student's Date of Birth: _____/_____/_____ Student's Age on Last Birthday: _____ Grade ___ for 20___- 20___ School Year

Winter Sport(s): _____ Spring Sport(s): _____

CHANGES TO PERSONAL INFORMATION (In the spaces below, identify any changes to the Personal Information set forth in the original Section 1: PERSONAL AND EMERGENCY INFORMATION):

Current Home Address _____

Current Home Telephone # ( )_____ Parent/Guardian Current Cellular Phone # ( )_____

CHANGES TO EMERGENCY INFORMATION (In the spaces below, identify any changes to the Emergency Information set forth in the original Section 1: PERSONAL AND EMERGENCY INFORMATION):

Parent's/Guardian's Name_____ Relationship _____

Parent/Guardian E-mail Address:_____

Address _____ Emergency Contact Telephone # ( )_____

Secondary Emergency Contact Person's Name _____ Relationship _____

Address _____ Emergency Contact Telephone # ( )_____

Medical Insurance Carrier _____ Policy Number _____

Address _____ Telephone # ( )_____

Family Physician's Name_____, MD or DO (circle one)

Address _____Telephone # ( )_____

If any SUPPLEMENTAL HEALTH HISTORY questions below are either checked yes or circled, the herein named student shall submit a completed Section 8, Re-Certification by Licensed Physician of Medicine or Osteopathic Medicine, to the Principal, or Principal's designee, of the student's school.
Explain "Yes" answers at the bottom of this form.
Circle questions you don't know the answers to.

	Yes	No
1. Since completion of the CIPPE, have you sustained a serious illness and/or serious injury that required medical treatment from a licensed physician of medicine or osteopathic medicine?	☐	☐
An additional note to item #1. if serious illness or serious injury was marked "Yes", please provide additional information below		
2. Since completion of the CIPPE, have you had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury?	☐	☐
3. Since completion of the CIPPE, have you experienced dizzy spells, blackouts, and/or unconsciousness?	☐	☐
4. Since completion of the CIPPE, have you experienced any episodes of unexplained shortness of breath, wheezing, and/or chest pain?	☐	☐
5. Since completion of the CIPPE, are you taking any NEW prescription medicines or pills?	☐	☐
6. Do you have any concerns that you would like to discuss with a physician?	☐	☐

#'s	Explain yes answers; include injury, type of treatment & the name of the medical professional seen by student

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Student's Signature _____Date___/___/____

I hereby certify that to the best of my knowledge all of the information herein is true and complete.
Parent's/Guardian's Signature _____Date___/___/____

Section 8: Re-Certification by Licensed Physician of Medicine or Osteopathic Medicine

This Form must be completed for any student who, subsequent to completion of Sections 1 through 5 of this CIPPE Form, required medical treatment from a licensed physician of medicine or osteopathic medicine. This Section 8 may be completed at any time following completion of such medical treatment. Upon completion, the Form must be turned in to the Principal, or the Principal's designee, of the student's school, who, pursuant to ARTICLE X, LOCAL MANAGEMENT AND CONTROL, Section 2, Powers and Duties of Principal, subsection C, of the PIAA Constitution, shall "exclude any contestant who has suffered serious illness or injury until that contestant is pronounced physically fit by the school's licensed physician of medicine or osteopathic medicine, or if none is employed, by another licensed physician of medicine or osteopathic medicine."

NOTE: The physician completing this Form must first review Sections 5 and 6 of the herein named student's previously completed CIPPE Form. Section 7 must also be reviewed if both (1) this Form is being used by the herein named student to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in a subsequent sport season in the same school year AND (2) the herein named student either checked yes or circled any Supplemental Health History questions in Section 7.

If the physician completing this Form is clearing the herein named student subsequent to that student sustaining a concussion or traumatic brain injury, that physician must be sufficiently familiar with current concussion management such that the physician can certify that all aspects of evaluation, treatment, and risk of that injury have been thoroughly covered by that physician.

Student's Name: _____ Age_____ Grade___ for 20___ - 20___ (School Year)

Enrolled in _____ School

Condition(s) Treated Since Completion of the Herein Named Student's CIPPE Form: _____

_____

_____

_____

_____

A. GENERAL CLEARANCE: Absent any illness and/or injury, which requires medical treatment, subsequent to the date set forth below, I hereby authorize the above-identified student to participate for the remainder of the current school year in additional interscholastic athletics with no restrictions, except those, if any, set forth in Section 6 of that student's CIPPE Form.

Physician's Name (print/type)_____ License #_____

Address_____ Phone ( )_____

Physician's Signature _____ MD or DO *(circle one)* Date_____

B. LIMITED CLEARANCE: Absent any illness and/or injury, which requires medical treatment, subsequent to the date set forth below, I hereby authorize the above-identified student to participate for the remainder of the current school year in additional interscholastic athletics with, in addition to the restrictions, if any, set forth in Section 6 of that student's CIPPE Form, the following limitations/restrictions:

1. _____
2. _____
3. _____
4. _____

Physician's Name (print/type)_____ License #_____

Address_____ Phone ( )_____

Physician's Signature _____ MD or DO *(circle one)* Date_____