"A SPORTING CHANCE"
PARTICIPATION CERTIFICATE

This form is to be completed prior to the first practice session. It contains vital information in case of injury. The Coach should keep a copy of this form and bring it to all events. The **"A Sporting Chance"** office should also have a copy on file.

SECTION 1: ATHLETES APPLICATION AND PERSONAL INFORMATION

Name: _____ Birth date: _____/_____/_____ M _____ F _____

Address: _____City, State, Zip _____Phone ( )_____

This application to participate in ***"A SPORTING CHANCE"*** events is entirely voluntary on my part. I understand that I will have to follow the rules and regulations of the program and I agree to follow these rules. I also understand that if I do not meet the sportsmanship standards or if I am ejected from an event because of an unsportsmanlike act, it could result in me not being allowed to participate in the next contest or suspension from the team, either temporarily or permanently.

I have completed and/or verify that part of this form requires me to list all previous injuries, disabilities, or additional conditions that are known to me that may affect my performance in participating in any event of ***"A SPORTING CHANCE".*** With my signature below, I verify that it is correct and complete.

Signed by athlete: _____ Date: _____

SECTION 2: PARENT PERMISSION AND AUTHORIZATION FOR TREATMENT

We hereby give our consent for the above named athlete to participate in ***"A SPORTING CHANCE"*** athletic events. We also give our consent for him/her to accompany the team on trips and will not hold the ***"A SPORTING CHANCE"*** organization responsible in case of accident or injury, whether in route to or from practice sessions or an athletic event. We also hereby agree to hold the ***"A SPORTING CHANCE"*** organization, its' employees, agents, representatives, coaches, and volunteers harmless from any and all liability, actions, causes of actions, debts, claims, or demands of every kind and nature whatsoever, which may arise by/ or in connection with participation by my child/ward in any activities related to programs by the not-for-profit organization named ***"A SPORTING CHANCE FOR SPECIAL POPULATIONS".***

If we cannot be reached and in the event of any emergency, we also give our consent for the ***"A SPORTING CHANCE"*** organization to obtain through a physician or hospital of its choice, such medical care as is reasonably necessary for the welfare of the athlete, if he/she is in the course of ***"A SPORTING CHANCE"*** activity.

We further state that we have completed the part of this certificate which requires us to list all previous injuries or additional conditions that are known to us, which may affect this athlete's performance or treatment, and we certify that it is correct and complete.

Please check sports that you would like to receive information about

Basketball = (January – March)	**Integrated Golf (June – September)**
Track & Field = (March – May)	**Volleyball = (September – December)**
Softball = (May - July)	**Bowling = (September – November)**

Swimming & Gymnastics are offered as recreational opportunities – not competition
We offer individual recreation in all sports – You do not have to be on a team

(Over)

A SPORTING CHANCE
Athlete Health Inventory
Parents Please Fill Out

Athletes Name: _____ Coaches Name:_____

(Check Yes or No)

DOES YOUR ATHLETE HAVE:	**YES / NO**		**YES / NO**
Allergies	____/____	Neck or Spine Injury	____/____
Asthma	____/____	Sickle Cell Trait	____/____
Bee Sting Allergy	____/____	Skin Condition	____/____
Diabetes	____/____	Enlarged Liver / Spleen	____/____
Ear Infections	____/____	**HAS YOUR ATHLETE HAD:**	
Seizures	____/____	Serious Illness	____/____
Heart Condition	____/____	Surgery (Operation)	____/____
Bone or Joint Problem	____/____	Childhood Disease	____/____
Behavioral Problem	____/____	**DOES YOUR ATHLETE:**	
Alcohol or Illicit Drug Use	____/____	Have trouble seeing close work	____/____
High Blood Pressure	____/____	Have trouble seeing at a distance	____/____
Absent Testicle, Ovary, Kidney, or Eye	____/____	Wear Glasses	____/____
Birth Defect	____/____	Wear Contact Lenses	____/____
Concussion	____/____	Have trouble hearing	____/____

Date of last Tetanus Immunization _____

INSURANCE COVERAGE

***"A SPORTING CHANCE"* by-laws provide that an athlete should have their own basic insurance coverage or be covered by Medicaid or Medicare. A Sporting Chance will be providing secondary insurance only.**

Our athlete is covered by basic insurance by: _____

(Name of insurance company or Medicaid number)

Signature of Parent or Guardian _____ Date: _____

MEDICATION NEEDS

Is your athlete on any medication on a regular basis? If so, please list.

_____

This information is accurate to the best of my knowledge. I certify that my athlete is not under the regular care of a physician for heart condition, asthma or a chronic condition requiring special care. **If under care for a heart condition athlete must have a release from his/her doctor in order to participate in A Sporting Chance events**.

Media Release

By my signature below I am granting permission to ***A Sporting Chance*** to use the athletes name, voice, picture or words in television, newspapers, radio, magazines or any other type of media. I realize that publicity of the athletes and their abilities helps promote the A Sporting Chance program and agree to help in anyway possible.

Parents Signature: _____ **Date:** _____

Athletes Signature:_____ **Date:** _____

(If athlete is 18 Years or Older)

Support Our Sports Campaign (See enclosure)

Cost to participate in the SOS Program is only $10 per family per month or you can make a Voluntary Donation (Send this form and your check to address below) (We will send monthly statement to your address) Please note: Joining the SOS campaign is voluntary. We have NO MANDATORY FEES.

Return to: A Sporting Chance
P.O. Box 11337
Springfield, MO. 65808-1337
Phone (417) 881-7373 or 1-800-334-7607

"S.O.S. CAMPAIGN"

(Support **O**ur **S**ports**)**

A Sporting Chance just celebrated our 17th anniversary and we still need funding sources. A Sporting Chance is now serving over 2,300 individuals a year. We **serve any person with any disability**, **Youth who are disadvantaged**, **"At Risk Teens**, **Abused & Neglected Children** and **Senior Citizens**.

Since our inception we continually try to receive grants or raise money any way we can. The Board of Directors approved our own "Pledge Campaign" to raise necessary funds. The campaign is an ***"S.O.S. Campaign" (Support Our Sports).***

The ***"S.O.S. Campaign"*** is an ongoing process. Below please find a **"Pledge Card"** that you can use to show your support. We are looking for people who will donate a minimum of $10 per month to help pay for the costs of rooms, meals, transportation, uniforms, facility rental, umpires, referees, uniforms, etc.

Each person or business who "Pledges" their support will receive a monthly bill to help make the payments easier. In addition, if you know friends, family, co-workers, hairdressers, neighbors, etc., who are looking for a good 501c3 organization, please ask at least one person to join our campaign.

This S.O.S. campaign will take the place of charging athletes for each event. If athletes, their families, their friends and others participate in the S.O.S. Campaign they will not be charged for any of the sports throughout the year.

We would appreciate your support and hope this is a tool that will help make us more financially secure.

Pledge Form

Name_____

Address_____

City, State, Zip_____

Phone: ( ) _____

We would like to join the SOS campaign to support A Sporting Chance. Please send us an invoice for $_____ a month or accept our donation of $_____ for an entire year.

Please note: Joining the SOS Campaign is voluntary. We have NO mandatory fees