



# PCA SUMMER CAMP 2023

We follow all Diocesan Guidelines, ensuring a safe, healthy, & fun environment for all! There will be safe outdoor play, STREAM activities, crafts, & kid friendly entertainment.

ALL REGISTERED K - 4<sup>TH</sup>  
GRADE WELCOME

## RESERVE YOUR SPOT NOW

(Camp times will be Monday-Friday from 8:30am-3:00pm)

Child(ren) Name(s) & Grade attending in Fall:

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June 19<sup>th</sup>-June 23<sup>rd</sup>: **FULL** SPY CAMP

June 26<sup>th</sup>-June 30<sup>th</sup>: **FULL** ANIMAL PLANET

July 10<sup>th</sup>-July 14<sup>th</sup>: SHARK WEEK

July 17<sup>th</sup>- July 21<sup>st</sup>: DINO WEEK

Rate Per Child(ren) Per Week

1 child: \$300/week

2 children: \$550/week

3 children: \$750/week

4 children: \$900/week

Camp weeks attending:

SPY CAMP **FULL** (June 19<sup>th</sup>-23<sup>rd</sup>)

ANIMAL **FULL** (June 26<sup>th</sup>-June 30<sup>th</sup>)

SHARK WEEK (July 10<sup>th</sup> - July 14<sup>th</sup>)

DINO WEEK (July 17<sup>th</sup> - July 21<sup>st</sup>)

If you have any questions, please contact us at [summercamp@pcapvb.org](mailto:summercamp@pcapvb.org)

YOUR RATE: \$ \_\_\_\_\_ X # of WEEKS: \_\_\_\_\_ = TOTAL DUE: \$ \_\_\_\_\_

\*\*\*DON'T FORGET to submit your completed and notarized Catholic Schools Physical form which is included with this Registration Form\*\*\*



## CATHOLIC GRADE SCHOOL SPORTS CONFERENCE STUDENT ATHLETIC PARTICIPATION APPLICATION

This form is effective from the date indicated on the form, until the end of the current school year. This form must be on file in the School office prior to any student participating in either tryouts or appropriate athletic practice or competition.

Student's Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_ Application Date \_\_\_\_\_

This application to compete in interscholastic athletics for \_\_\_\_\_ School is entirely voluntary on my part and is made with the understanding that I have not violated any of the eligibility rules and regulations. \_\_\_\_\_

Signature of Student

Parent or Guardian's permission: I hereby give my consent for the above student to engage in school approved athletic activities as a representative of his/her school. I agree to allow the above-named student to be a passenger in a privately operated vehicle to and from athletic events. I hereby release and discharge the Diocese of St. Augustine, Bishop Erik T. Pohlmeier, \_\_\_\_\_ School, its agents and employees from liability growing out of personal injuries and property damage resulting or occurring during transport to and from said activity.

Date \_\_\_\_\_ Signature of Parent or Guardian \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Tel. # \_\_\_\_\_

### MEDICAL RELEASE: SIGN THIS SECTION ONLY IN THE PRESENCE OF YOUR NOTARY PUBLIC.

The patient and others, whose signatures appear below, do hereby consent to any and all medical, dental and surgical treatments including anesthesia and operations, which may be deemed advisable by his/her physicians and surgeons as a result of his/her participation in athletic activities. The intention hereof being to grant authority to administer and to perform all and singularly any examinations, treatments, anesthetics, operations, and diagnostic procedures which may now or during the course of the patient's care be deemed advisable and necessary. This form will be used only in case of emergencies and after every reasonable effort is made to contact parents/guardians prior to admitting the patient for necessary treatment. Consent is also given for release of information for insurance purposes, and I submit authorization for responsible third party to pay directly to the treating hospital, insurance benefits due me for services rendered.

**HIPPA Consent/Authorization:** I hereby authorize the physicians, athletic trainers, sports medicine staff and other health-care personnel representing Jacksonville Orthopedic Institute to release information regarding my student athlete's protected health information and regarding any injury or illness during training for and participation in athletics at \_\_\_\_\_ School. This information is only to be used for the betterment of the student athlete and can only be shared with a coach, athletic director, or school official in connection with participation in interscholastic sports. This protected health information may concern the student athlete's medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable health information. This protected information may be released to other health care providers, hospital and/or medical athlete's participation in \_\_\_\_\_ School athletics.

**SIGNATURES (both required):**

Minor Patient \_\_\_\_\_ Parent or Guardian \_\_\_\_\_

Address (if different) \_\_\_\_\_

Family Physician \_\_\_\_\_ Emergency Tel. # \_\_\_\_\_

STATE OF FLORIDA, COUNTY OF \_\_\_\_\_ before me personally appeared \_\_\_\_\_

To me well known and known to me to be the person described in and who executed this foregoing instrument and acknowledged to and before me that executed said instrument for the purposes therein expressed.

Notary Public, State of Florida at Large \_\_\_\_\_ Date \_\_\_\_\_ (Seal)

### ACKNOWLEDGEMENT OF WARNING BY PARENTS

We/I the parent(s) of \_\_\_\_\_ do hereby acknowledge that we/I have been fully advised, cautioned and warned by the proper administrative and coaching personnel of \_\_\_\_\_ that our/my child named above may suffer serious injury, including but not limited to sprains, fractures, brain damage, paralysis or even death, by participating in the sport of \_\_\_\_\_. Notwithstanding such warnings, and with full knowledge and understanding of the risk of serious injury to our/my child named above which may result, we/I give our/my consent to \_\_\_\_\_ to participate in the sport of \_\_\_\_\_.

Witnesses \_\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_

A. \_\_\_\_\_ Physical exam forms must be on file with the school before tryouts/practice.

B. \_\_\_\_\_ Medical history on reverse side must be completed by parent or guardian.



## CATHOLIC GRADE SCHOOL SPORTS CONFERENCE MEDICAL HISTORY SHEET

STUDENT'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

**CIRCLE YES OR NO (FURTHER DESCRIBE YES ANSWER TO THE RIGHT)**

- YES NO HISTORY OF HIGH BLOOD PRESSURE \_\_\_\_\_
  - YES NO HISTORY OF HEART OR BLOOD VESSEL DISEASE \_\_\_\_\_
  - YES NO LIVER OR KIDNEY PROBLEMS \_\_\_\_\_
  - YES NO PREVIOUS STROKES - C.V.A. \_\_\_\_\_
  - YES NO DIABETES \_\_\_\_\_
  - YES NO EPILEPSY \_\_\_\_\_
  - YES NO RESPIRATORY DIFFICULTIES \_\_\_\_\_
  - YES NO BROKEN BONES \_\_\_\_\_
  - YES NO SENSORY DISTURBANCES \_\_\_\_\_
  - YES NO ARTHRITIS OR JOINT PROBLEMS \_\_\_\_\_
  - YES NO SPECIAL DIET RESTRICTIONS \_\_\_\_\_
  - YES NO PRESENTLY HAVE ANY METAL IMPLANTS \_\_\_\_\_
  - YES NO PRESENTLY HAVE A PACEMAKER \_\_\_\_\_
  - YES NO ANY PRESENT VISUAL PROBLEMS \_\_\_\_\_
  - YES NO ANY PRESENT HEARING PROBLEMS (HEARING AID) \_\_\_\_\_
  - YES NO ANY UNUSAL REACTION TO HEAT OR COLD \_\_\_\_\_
  - YES NO ANY ALLERGIES \_\_\_\_\_
  - YES NO CONCUSSIONS (LIST DATES) \_\_\_\_\_
- LIST CURRENT MEDICATIONS \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

LIST PREVIOUS MAJOR HOSPITALIZATION/SURGERIES \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 PARENT OR GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**PHYSICAL EXAM BY PHYSICAN**

Height (inches) _____	Weight (pounds) _____
Blood Pressure _____	Pulse _____
Vision _____	Contacts/glasses _____

	WNL	ABN		WNL	ABN
HEENT _____			ANKLE _____		
NECK _____			ALIGNMENT _____		
LUNGS _____			STABILITY _____		
HEART _____			FEET _____		
ABDOMEN _____			KNEE _____		
GENITALS _____			MCL _____		
SKIN _____			LCL _____		
NECK _____			ACL _____		
SPINE _____			PCL _____		
SHOULDER _____			MENISCUS _____		
STABILITY _____			PATELLA _____		
IMPINGEMENT _____			PAIN _____		
ELBOW _____			APPREHENSION _____		
WRIST _____			CREPITATION _____		
HAND _____			FUNCTIONAL TEST _____		
HIP _____			ONE LEG HOP _____		
			FULL SQUATS _____		

NEEDS FURTHER EVALUTION \_\_\_\_\_ YES NO  
 CLEARED FOR PARTICIPATION \_\_\_\_\_ YES NO

COMMENTS: \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 PHYSICIAN'S/NURSE PRACTITIONER'S/PHYSICIAN'S ASSISTANT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_