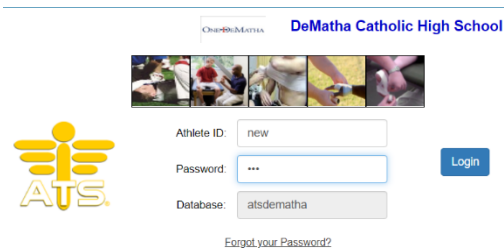



Creating an ATS Profile & Uploading Documents

1. *Computer access:* atsdematha2.atsusers.com
Smartphone/tablet access: atsdematha4.atsusers.com
2. If creating a profile for the first time, type “new” in as your Athlete ID and Password. The database should autofill as “atsdematha”



DeMatha Catholic High School



Athlete ID:

Password:

Database:

Login

[Forgot your Password?](#)

If you have previously created an account, log in with the credentials you selected. If you don't have that information, DO NOT create a new account. Email jreading@dematha.org to recover credentials.

3. Complete all yellow boxes, as well as including a valid contact phone number and mailing address. There is space on this page to create an ID and password here. Please also include any medications, allergies, or other notable medical information at the bottom of the page.
4. Click “save athlete information”
5. Blank copies of all required medical forms can be found under the “eFiles” tab. This is also where completed documents will be uploaded when complete.
6. ALL incoming students are required to submit a physical dated after June 1st of the current school year, a complete immunization record, a medical history form, emergency contact form, and the Safe Sports Agreement. Athletes will be required to submit 2 additional forms, the permission release and handbook form out of the Parent Handbook. All of these forms are accessible via the DeMatha website, the eFiles tab in an ATS account, and were given as hard copies in a student's enrollment package.

DeMatha Catholic High School

Handbook

For

Parents of Athletes

We believe that one of our foremost educational objectives in working with young men in a sports setting is to foster the development of responsible and ethical behavior. For this reason, we would like each athlete and parents of the athlete to become familiar with this aspect of our coaching philosophy and to indicate his/her awareness of this philosophy by signing below.

1. **Please include your \$30 weight room fee with this form if applicable.** (see Weight Room Fee, excludes basketball, football, and lacrosse)
2. **Please sign and return the PERMISSION FORM AND RELEASE.** (this can be done electronically).

If the form and fee are not returned by the stated date, your son will be ineligible until so done.

_____ Athlete	_____ Parent
Print	Print
_____ Athlete	_____ Parent
Sign	Sign

_____ Sport

Circle the Level - Varsity
 - Junior Varsity
 - Freshmen

This form must be signed and returned to your coach along with your check by the following dates. Updates may occur at any time during the year.

Fall August 12

Varsity Football Aug. & Soccer August 3

Winter November 18

Spring March 2



DeMATHA CATHOLIC HIGH SCHOOL

Order of the most Holy Trinity and of the Captives

UNITED STATES DEPARTMENT OF EDUCATION
TWICE RECOGNIZED SCHOOL OF EXCELLENCE



Athletic Department

Baseball

PERMISSION FORM AND RELEASE

Student Name: _____ Birth Date: _____

Basketball

Parent / Guardian Name: _____

Crew

Home Phone: _____ Cell Phone: _____

Cross Country

Sport: _____ School Year: _____

Football

I, the undersigned parent or legal guardian of the above named student (the "Student"), give my permission for the Student to attend and participate in all activities associated with the above referenced sport as a student of DeMatha Catholic High School ("DeMatha"). This permission extends to any and all activities related to or arising out of participation in this sport, including training, out of season activities (OSAs), practice, games, events, and the transport, to, from, and during any such activities. Although the majority of the travel for the sport will be local, activities associated with the sport may require travel overnight and/or outside of the Baltimore-Washington, D.C. metropolitan area. Thus, this permission extends to all travel of any kind or length associated with the sport, including but not limited to transport by any vehicle operated by any volunteer or employee approved by DeMatha or any third-party transportation company or commercial carrier engaged by DeMatha or any overnight lodging. A schedule of games, meets, matches, or events for the sport is posted on DeMatha's website or will be provided to the student.

Golf

Hockey

Lacrosse

Rugby

In consideration of the opportunity for the Student to participate in this sport, I do hereby, for myself, the Student, and our heirs, estate, executors, administrators, assigns, and family members, **VOLUNTARILY ASSUME** all risks associated with the Student's participation in the sport and **IRREVOCABLY AND UNCONDITIONALLY RELEASE, HOLD HARMLESS, AND INDEMNIFY** DeMatha, the Order of the Most Holy Trinity and of the Captives, and their former, current, and future agents, employees, officers, directors, volunteers, representatives, affiliated organizations and entities, and other participants (collectively, the "School") to the fullest extent permitted by law from any and all liability, claims, demands, and causes of action arising out of or relating to any loss, damage, COVID-19, or injury (including death) sustained in connection with or arising out of the Student's participation in the sport, including all associated travel and any actions taken by the School pursuant to this permission form and release. By my signature below, I also acknowledge that participating in the sport (whether training, practices, games, events, or otherwise) and transportation involves risk of injury to the Student, including permanent disability, death, and economic loss, which might result from the activities of the sport, the acts or inactions of others (including of other competitors or vehicle operators), the unavailability of emergency medical care, and/or the inherent risks of the sport or of transportation. I fully understand, appreciate, and hereby assume and voluntarily accept all of the dangers and risks related to the Student's participation in this sport, whether on DeMatha's campus or elsewhere and including all associated travel, and I have voluntarily elected to allow the Student to participate in this sport.

Soccer

Swimming

Tennis

Track Indoor Outdoor

Wrestling

 X

Date of Signature

Parent/Guardian Signature

 X

Date of Signature

Witness Signature

 X

Witness Name (Printed)

PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____ Grade _____

- 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?
- Do you wear a seat belt, use a helmet, and use condoms?
- Do you ever use cigarettes, chewing tobacco, snuff, or dip?
- Have you in the past 30 days?
- 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?

EXAMINATION		
Height	Weight	BP / Pulse
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)		
Skin (HSV, lesions suggestive of MRSA, tinea corporis)		
Neurologic		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Fingers/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/toes		
Functional (Duck-walk, single leg hop)		

- ☐ Cleared for all sports without restriction
- ☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for: _____
- ☐ Limited Participation: _____
- ☐ Clearance withheld until: _____

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 _____

Signature of Physician _____ Phone _____

HISTORY FORM

Name _____ Birthdate _____ Grade _____

Sport(s) playing at DeMatha _____

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

Please list any allergies? _____

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: • Asthma • Anemia • Diabetes • Infections Other: _____			
3. Have you ever been diagnosed with a learning disability?			
4. Have you ever been diagnosed with ADD or ADHD?			
5. Have you ever received treatment for anxiety, depression, or any other mental illnesses?			
6. Have you ever spent the night in the hospital?			
7. Have you ever had surgery?			
HEART HEALTH QUESTIONS ABOUT YOU		Yes	No
8. Have you ever passed out or nearly passed out DURING or AFTER exercise?			
9. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			
10. Does your heart ever race, skip or feel irregular during exercise?			
11. Has a doctor ever told you that you have any heart problems? If so, circle all that apply: • High blood pressure • A heart murmur • High cholesterol • A heart infection • Kawasaki disease Other: _____			
12. Has a doctor ever ordered a test for your heart? (ECG/EKG, echocardiogram, etc.)			
13. Do you get lightheaded or feel more short of breath than expected during exercise?			
14. Have you ever had an unexplained seizure?			
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		Yes	No
15. 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)?			
16. 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?			
17. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			
18. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			
BONE AND JOINT QUESTIONS		Yes	No
19. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			
20. Have you ever broken or fractured bones or dislocated joints?			
21. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?			
22. Have you ever had a stress fracture?			
23. 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)			
24. Do you regularly use a brace, orthotics, or other assistive device?			
25. Do you have a bone, muscle, or joint injury that bothers you?			
26. Do any of your joints become painful, swollen, feel warm, or look red?			

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

Explain "yes" answers: _____

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

Student Signature _____ Date _____

Guardian Signature _____ Date _____

STUDENT ATHLETE EMERGENCY FORM

Name _____ Birthdate _____ Grade _____

Parent/Guardian Name(s) _____

Home Address _____

Athlete Resides with: _____ Mother _____ Father _____ Both _____ Other _____

Contact Phone Number #1 _____ Email address: _____

Contact Phone Number #2 _____ Email address: _____

Emergency contact if guardian cannot be reached: _____

Allergies: _____ Current Medications: _____

Any notable medical problem we need to be aware of: _____

I hereby give permission to a physician, athletic trainer, or medical center to provide medical services to my child.

Signature _____ Date _____

If my child is sick or incurs an injury, I give permission to the athletic trainer to administer over the counter medications and topicals (including but not limited to ibuprofen, acetaminophen, cold remedies, diphen, triple antibiotic ointment).

Signature _____ Date _____

INSURANCE INFORMATION

Students are not allowed to participate on interscholastic teams without health insurance.

Insurance company name _____ Insurance co phone number _____

Insurance co address _____

Insurance is provided through (employer's name) _____

Policy holder's name _____ Policy Holder's Date of Birth: _____

Policy # _____ Member ID/Group # _____

Authorization to release benefits to medical center/hospital

Signature _____ Date _____

STUDENT PARTICIPATION AND PARENTAL APPROVAL

THIS APPLICATION TO COMPETE IN INTERSCHOLASTIC ATHLETICS IS ENTIRELY VOLUNTARY ON MY PART AND IS MADE WITH THE UNDERSTANDING THAT I HAVE NOT VIOLATED ANY OF THE ELIGIBILITY RULES/REGULATIONS OF DEMATHA AND THE WCAC Participation in high school athletics has many rewards and can provide tremendous enjoyment. However, it is important for both the participant and his parents to realize that an element of physical risk is present when one is involved in athletics. The purpose of this statement is to clarify the school's position in terms of insurance coverage and to obtain your permission to treat him medically if your son should be injured.

DeMatha's insurance coverage, like that of all schools, does not cover personal injury that is the result of athletic participation. You must provide your own health insurance for athletic participation. It is important that you check with your own insurance carrier to be certain that athletic injury for your son is covered by your policy. If a family does not provide insurance coverage, a student is not eligible to participate on school interscholastic athletic teams. The school's insurance policy does cover injury that would result from an accident incurred with school transportation going to and from practice or game sites. Students who chose to provide their own transportation must carry their own insurance coverage. Likewise, students and/or parents who volunteer to transport others to and from practice and/or game sites are not covered by school insurance.

Acknowledging and understanding this: "I hereby give my consent to the above named student to represent his school in athletic activities for which the attending physician has given medical clearance; to accompany any school team of which he is a member to any of its local or out of town trips. I authorize school personnel (coaches, athletic trainer) to obtain, through a physician of their own choice, any emergency medical care that may become necessary for the student in the course of such athletic activities or such travel. I understand and agree that I am the responsible party for any medical expenses that may occur from such an emergency or any medical care given. I also agree to not hold the school or anyone acting in its behalf responsible for any injury occurring to the above named student in the course of such athletic participation or travel."

Signature _____ Date _____

Athlete Signature _____ Date _____



I, _____, parent of _____
have visited the sites and read the information under the section
“Safety Concerns For Parents To Consider” on the DeMatha Athletic
webpage. I understand that the information presented can help me
keep my son safe and healthy while participating in athletics at
DeMatha.

Parent Signature _____ Date _____



safe sports school
NATIONAL ATHLETIC TRAINERS' ASSOCIATION

CHILD'S NAME _____		LAST _____	FIRST _____	MI _____
SEX: MALE <input type="checkbox"/>	FEMALE <input type="checkbox"/>	BIRTHDATE _____ / _____ / _____		
COUNTY _____	SCHOOL _____		GRADE _____	
PARENT OR GUARDIAN NAME _____		PHONE NO. _____		
GUARDIAN ADDRESS _____		CITY _____		ZIP _____

Vaccines Type													
Dose #	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/Yr
1									1				
2									2				
3										Td Mo/Day/Yr	Tdap Mo/Day/Yr	FLU Mo/Day/Yr	
4										_____	_____	_____	_____
5										_____	_____	_____	_____

1.	Signature (Medical provider, local health department official, school official, or child care provider only)	Title	Date
2.	Signature	Title	Date
3.	Signature	Title	Date

Center for Immunization
www.dhmm.maryland.gov