



STS. BRUNO & RICHARD SCHOOL SPORTS PROGRAM
 2024-2025
 5025 S. Kenneth Ave. 773-582-8083
 Chicago, Illinois 60632

STUDENT-ATHLETE REGISTRATION FORM

Child's Name: _____ Grade: _____

Parents Names: _____

Address: _____ City, State, Zip code _____

Parent's Cell Phone Number(s) _____

Registration Fee: **\$150.00 per student for first sport**
\$50.00 per student for each additional sport
 All fees must be turned in with the registration forms.
 Fees can be paid electronically through QR code provided below.

Please check the box for each sport in which the student would like to participate.

| | Varsity (7 th – 8 th) | J V (5 th – 6 th) | Pee Wee (3 rd - 4 th) | Bitty Basketball Coed (1 st – 2 nd) |
|--------------------|---|---|---|---|
| Girl's Basketball* | | | | |
| Boy's Basketball* | | | | |

| | Varsity (7 th – 8 th) | J V (5 th – 6 th) | Pee Wee (3 rd - 4 th) |
|--------------------|---|---|---|
| Girl's Volleyball* | | | |
| Boys' Volleyball* | | | |

| | Varsity (7 th – 8 th) | J V (5 th – 6 th) | Pee Wee (3 rd – 4 th) | Bitty (1 st – 2 nd) | Half Pints (PK – K) |
|---------------|---|---|---|---|------------------------|
| Co-ed Soccer* | | | | | |
| | | | | | |

****Availability of sports may change depending on the number of coaches available.***

For office use only

| Date | Registration form & Medical questionnaire completed | Fee amount paid Ck # if applicable | Rules Agreement completed | Notes |
|------|---|---------------------------------------|---------------------------|-------|
| | | | | |





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STUDENT- ATHLETE MEDICAL QUESTIONNAIRE

Child's Name:

Grade:

In an effort to help provide optimum health service for your child and keep your child's student/athlete health record complete and up to date we ask you cooperation in providing the following information.

1. Has your child had any serious illness, operation or injury? Yes No
If yes, please specify:

2. Does your child have any serious medical problems? Yes No
(ie: Diabetes, epilepsy, heart condition, seizures, etc.)?
If yes, please note the problem/treatment/medication.

3. Does your child have any known allergies? Yes No
If yes, please note allergy and the treatment.

4. Does your child have asthma? Yes No
If yes, please note medication and restrictions, if any

5. Is your child allergic to bee/insect stings? Yes No
If yes, specify treatment procedure.

6. Is your child on any medications? Yes No
If yes, please specify.

7. Does your child need prescription medication during sports? Yes No
If yes, a "School Medication Permission Form" will be
forwarded to you to complete. Inform the school if one is needed.

8. Does your child have any vision/hearing problems? Yes No
If yes, please comment. If a child wears glasses, please note.

Parent/Guardian Signature

Date

