SOUTHERN CALIFORNIA JUNIOR ALL AMERICAN CONFERENCE, INC.
20__ PLAYER'S SEASON CONTRACT

(PLEASE READ CAREFULLY) Rev. 1/16

SECTION I

SCJAAFC Chapter _____ Team Name _____

CHECK STATUS ☐NEW ☐ RETURNING

CHECK DIVISION: ☐FLAG ☐JR. MICRO ☐MICRO ☐JR. PEE WEE ☐PEE WEE ☐MIDGET ☐CHEERLEADER ☐ 7v7 League

SECTION II **TO BE COMPLETED BY CANDIDATE PLAYER & PARENTS**

NO CANDIDATE will be permitted to participate in any activity until SECTIONS II, III, and VII of this Contract has been completed in full. The CANDIDATE PLAYER agrees that he will faithfully abide by the Rules of the SCJAAFC to the very best of his ability.

Last Name	First	Middle	Birth date	Age	School & grade

Address	City	Zip

Home phone number	Cell number Parent/Guardian	Cell number Parent/Guardian	Email address

SECTION III **EQUIPMENT RESPONSIBILITY**

I/We as parent/guardian of said candidate do hereby assume full and complete for the proper care and maintenance of all equipment loaned by Local Chapter to said candidate. I understand all equipment is to be used for SCJAAFC activities only and that all equipment remains the legal property of Local Chapter. I agree to reimburse Local Chapter for any and all equipment that is lost, damaged or stolen for the full replacement cost of said equipment, with payment due when equipment is requested by Local Chapter, or immediately upon the withdrawal of said candidate from Local Chapter.

RULES AND REGULATION

I/We as parent/guardian of said candidate understand it is the responsibility of the parent/guardian, candidate, team and chapter to comply with any and all rules and regulations of SCJAAFC and Local Chapter. Any noncompliance with rules and regulations shall be cause for disciplinary action to be taken against said candidate, parent/guardian, team or chapter by SCJAAF

SCJAAFC.PARENT/GUARDIAN: Signature _____ Print Name _____ Date: _____

CHECK RELATIONSHIP TO MINOR ☐ FATHER ☐ MOTHER ☐ LEGAL GUARDIAN **(LEGAL PROOF ATTACHED)**

SECTION IV **PROOF OF AGE (to be completed by Athletic Director)**

FULL Legal Name: _____ Birth date _____

(No Nicknames) (Please print!) (Month, Day, Year)

Proof of Age: ☐ Birth Cert ☐ Abstract ☐ Gov't ID ☐Record of foreign birth ☐ School Record

SECTION V **FOR RESPONSIBLE CHAPTER AND TEAM OFFICIALS ONLY**

In approving the above Candidate's Player Season Contract, we hereby certify that the Birth Certificate/ Proof of Age submitted does correspond with the name and birth date shown in Sections II and IV. In addition, we hereby certify that the Parental Consent and the attached Medical Treatment Authorizations, was completed, and, together with the Medical Examination, was completed by the qualified Doctor of Medicine listed, prior to the Candidate's participation in any manner with this team. We certify that we have explained fully the procedures to follow in the event of injury, and that injury/insurance reporting must be performed in accordance with SCJAAFC rules and procedures. Finally, we certify that a copy of the Player Season Contract was furnished to the Parent(s) or Guardian, as applicable.

Responsible Chapter Official	Date	Certifying Team AD	Date

Team/ Division/ Chapter	Team/ Division/ Chapter

ABOUT THE CONFERENCE/LEAGUE INSURANCE COVERAGE

SECTION VI. **PARENTAL CONSENT**

I/We the parents/guardians of the minor named in Section II Candidate for a position on a SCJAAFC Team, hereby give my/our approval to his/her participation in any and all SCJAAFC activities during the current season. I/We assume all risks and hazards incidental to such participation, including transportation to and from such activities. I/We do hereby waive, release, absolve, indemnify, and agree to hold harmless the team, the Chapter, and the SCJAAFC including sponsors and other related participants, for any injury to my/our child. SCJAAFC has advertising, modeling and photo copyrights.

MEDICAL TREATMENT AUTHORIZATION

The SCJAAFC has Secondary Excess Accident-Medical Group Insurance coverage, with a deductible amount for each injury incurred. The SCJAAFC group insurance is "**SECONDARY EXCESS COVERAGE**," over any valid collectable coverage provided by the parent's separate personal or employee's dependent group insurance. The SCJAAFC secondary group covers one year from date of first treatment, for each injury, with dental coverage, for sound natural teeth, including dental X-rays. Abdominal hernia and pre-existing conditions are excluded. In executing the foregoing release, I/we, the under- signed acknowledge and represent that I/we understand that any claim for injuries which arises out of our child's participation, must be reported to the Team or Chapter Officials "**IMMEDIATELY**". The insurance claim form must be filled out and delivered to the Conference Insurance Commissioner "**WITHIN 30 DAYS**" from the date of injury. I/We have read the foregoing release, understand it and signed it voluntarily.

THE NAME OF OUR OWN AND/OR EMPLOYMENT GROUP INSURANCE COMPANY IS:

_____

POLICY NUMBER: _____

(IF NO INSURANCE, List Father's or Mother's Soc. Security No.)

In the event of injury to MY/OUR Child, I/We hereby grant authority to a qualified Doctor of Medicine to render such medical treatment as said Doctor of Medicine deems necessary under the circumstances. **PLEASE LIST ALL ALLERGIES** _____

A. IMPORTANT NOTICE (State required "Disclosure" statement; C.I.C. Section 10270.2)

THIS IS AN EXCESS PLAN – The Medical Expense Benefit of this Plan (Program) is an "EXCESS" type benefit that picks up where other coverage leaves off. If you have any other individual, franchise, blanket or group (except automobile medical payments insurance) coverage which provides benefits of services for, or by reason of, medical or dental care or treatment, then this Plan (Program) will pay ONLY the medical expenses not provided or reimbursable under your other coverage. The premium for this Plan (Program) has been reduced, taking this into account.

If you have any other coverage, you should first submit you claim under that coverage. You should submit a claim under this Plan (Program) only if you have no other coverage or if your other coverage does not fully provide or pay for your medical care or treatment. Failure to submit the claim to your primary carrier can result in delaying payment by SCJAAFC insurance carrier.

B. The Conference/League insurance is "EXCESS" only. This means that the Parents/Guardians OWN INSURANCE MUST BE NOTIFIED OF THE INJURY. If the Parents/Guardians have insurance WITH PRE-PAID MEDICAL PLANS, such as Kaiser or Ross Loos, the injured person MUST BE TAKEN TO THE PRE-PAID MEDICAL FACILITIES, for treatment.

C. If insured's Parent's/Guardians HAVE NO OTHER 1st OR PRIMARY INSURANCE; the Conference/League group insurance may be used. BUT THERE IS A **$1000.00** DEDUCTIBLE FOR EACH INJURY.

D. The Conference/League group insurance PAYS ONLY TO THE HOSPITALS AND DOCTORS unless receipts are submitted showing proof of payment by Parent/Guardian to the Hospital/Medical Treatment center. The following forms are required to process the claim. 1. Insurance Claim Form. 2. Chapter AD report of injury. 3. Copy of Parent/Guardian Insurance card. 4. Hippa Form (on www.scjaaf.com). 5. Copy of any medical bills. 6. Copy of player's contract.

E. Any and all claims MUST be reported to your Chapter AD. The Chapter AD will then notify SCJAAF.

_____ _____

Name (Please Print) Relationship to Minor (Parent or Legal Guardian)

_____ _____

Signature Date Signed

Jr All American of Southern California Conference
Mandatory Medical Release Form
Chapter Name_____ Division_____

This form must be **dated AFTER March 27, 2020 AND within 4 months prior to first day of practice** and submitted to your Local Chapter. Section I must be completely filled out by the parent or legal guardian. Section II must be completed in its entirety ONLY by a duly qualified Doctor of Medicine, Doctor of Osteopathy, Nurse Practioner, or Physician's Assistant. **A Doctor of Chiropractic and a Registered Nurse are not considered to be qualified to give a physical to a player and a physical will not be accepted from one**

Section 1: FILLED OUT BY PARENT OR LEGAL GUARDIAN (Legal name must match proof of age)

Last: _____First: _____ Middle: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____Age _____ DOB: _____ Circle M / F

PARTICIPANTS MEDICAL HISTORY

1. **Are there any injuries requiring medical attention? Yes/ No**
2. **Is the participant currently under the care of a doctor? Yes/ No**
3. **Does the participant have any allergies (bee sting, penicillin)? Yes/ No**
4. **Is the participant diabetic/ require medication for Diabetes? Yes/ No**
5. **Does/ has the participant have/had seizures? Yes/ No**
6. **Are there any past surgeries/scheduled surgeries? Yes / No**
7. **Is the participant currently taking any medication? Yes / No**
8. **Does the participant have asthma/require inhaler Yes / No**
9. **Does the participant wear glasses or contact lenses? Yes/ No**
10. **Does the participant have any physical limitation/ medical condition Yes/ No**
11. **Does the participant wear a brace or other medical support Yes/ No**

If you answered YES to any question above, please provide the question number and an explanation below:

_____

_____

I hereby certify that this information is accurate to the best of my knowledge. I hereby acknowledge that it is my responsibility to inform my child's coach or organization official in writing if there is any change in the medical condition of my child. I also understand that is my responsibility to obtain written clearance from my child's physician on official medical stationary in order to seek permission for my child to resume participation after any and all such injury, illness or accident.

Signed_____ Print Name_____

Relationship to Participant_____ Dated_____

Section II: THIS SECTION IS TO BE COMPLETED ONLY BY A STATE LICENSED MEDICAL PROFESSIONAL

If there are any cross outs, white out, or information written over on this form, this form will be denied and a new physical required

Participant'sName:_____

(Please check the following if healthy or note otherwise): Height _____ Weight _____ (lbs) B/P _____

Ears_____ Mouth _____ Nose_____ Throat_____ Respiratory _____Cardiovascular_____ Neurological _____

Eyes_____/_____Hernia(optional)_____

Notes:_____

_____

_____I hereby certify that I am a licensed state examiner and have examined the above named individual and understand that he/she will be involved in participating in SCJAAF Football or Cheer Program. I hereby swear and attest that this individual is physically fit and I have found no medical reason which would prevent this individual from safely participating in SCJAAF Football activities for the 2019 season. I am therefore clearing this individual for athletic participation without limitation.

Signed_____Print Name_____

Date: _____ ____ Date Physical was actually performed: _____

A Doctor of Chiropractic and a Registered Nurse are not considered to be qualified to give a physical to a player and a physical will not be accepted from one

Address_____ Mandatory Dr. Stamp Here:

City_____ State_____

Telephone _____

MURRIETA BRONCOS

JR. ALL AMERICAN FOOTBALL & CHEER

PARTICIPANT NAME:

_____

Age as of July 31, 2020: _____

Division of Play: _____

Completed Player Contract: _____

Refund Policy/Parent Code of Conduct/Draft Policy: _____

Paid: _____ Date Paid: _____

Form of payment/amount:

Check# _____ Notes:

Cash: _____

Card: _____

Spirit Wear Sizes (Tackle Only):

YOUTH: XS___ S___ M___ L___ XL___

ADULT: S___ M___ L___ XL___

SHOE SIZE (for socks):_____

I, the undersigned, agree to pay the amount listed on the check. I also agree to pay no less than $25.00 for the bank fee if my check is returned for any reason.

Name: _____ Signature: _____

Comments: _____ Date: _____

MURRIETA JUNIOR ALL AMERICAN FOOTBALL & CHEER

TACKLE: ____ FLAG: ____ CHEER:____

TEAM: _____ DIVISION: (Division I / By Invite Only) _____

PARENT/PLAYER INFORMATION (Please Print Clearly)

NAME OF PLAYER: _____

ADDRESS: _____

CITY: _____ ZIP CODE: _____

HOME PHONE #: ( ) _____

FATHER'SNAME: _____

WORK PHONE#: _____ CELL PHONE #: _____

E-MAIL ADDRESS: _____

MOTHER'S NAME: _____

WORK PHONE#: _____ CELL PHONE#: _____

E-MAIL ADDRESS: _____

(Please make sure you have listed an email address you check often as this is our primary form of communication)

MEDICAL INFORMATION:

MEDICAL CONDITION(S): _____

EMERGENCY CONTACT INFORMATION:

NAME: _____ RELATIONSHIP: _____

PHONE#: _____ CELL #: _____

PARENT SIGNATURE: _____ DATE: _____

MURRIETA JR. ALL AMERICAN
FOOTBALL & CHEER

PARENT SIGNATURE PAGE

I have read and, or received a copy of the Murrieta Junior All American "Refund Policy," "Parent Code of Conduct," and "Draft Policy." By signing this I understand and agree to all the terms.

PLAYER NAME **TEAM/DIVISION**

REFUND POLICY **PARENT SIGNATURE & DATE**

PARENT CODE OF CONDUCT **PARENT SIGNATURE & DATE**

DRAFT POLICY **PARENT SIGNATURE & DATE**