

**THOMPSON SCHOOL DISTRICT
CHECKLIST FOR ATHLETIC PARTICIPATION**

Check as completed	Revised 5/30/14
_____	<p>Part A - PARENT PERMIT FOR ATHLETIC PARTICIPATION AND INSURANCE COVERAGE</p> <p>Read and complete with parent or guardian. Release must be signed by parent and <i>returned to the school office.</i></p>
_____	<p>Part B – SIGNATURE PAGE</p> <p>Acknowledgement for Code of Conduct, Training Rules and Standards for Communication Health Information Medicaid Information Student Eligibility Information CHSAA form</p>
_____	<p>PART C - MEDICAL</p> <p>Part I Medical History Complete with your parents and obtain signatures prior to physical examination.</p> <p>_____</p> <p>Part II Physical Examination Must be completed by a M.D., D.O., D.C., Spc. or nurse practitioner. Schedule your appointment well in advance - at least two months of your sports season. It is best to wear shorts and t-shirts to exam. To be valid, a physical must have been given within the last 365 calendar days.</p> <p><i>Both parts to be returned to the school office.</i></p>
_____	<p>Part D - ATHLETIC INJURY/ EMERGENCY INFORMATION</p> <p>Thompson School District OCR</p> <p>_____</p> <p>Athletic Injury Emergency Information</p> <p>Both forms must be signed and completed at the beginning of each season of participation.</p>
	<p>ATHLETIC FEE:</p> <p>A \$125 high school enrolled /\$175 high school non-enrolled. A \$150 football equipment fee for all first time participants. (This fee does not count towards the family maximum). \$50 middle school enrolled/\$70 middle school non-enrolled or \$20 intramural enrolled / \$30 intramural non-enrolled athletic fee must be paid before the issuance of clearance to participate. There is a yearly maximum of \$450 per family; \$125 for middle school and \$325 per high school, which also includes the school fee collected for Knowledge Bowl, Band, Choir, Orchestra and Forensics. There is NO yearly maximum for non-enrolled fees. Those students on the free/reduced lunch program may request a waiver from this fee. Any other students having a financial hardship may see the athletic director to discuss a waiver of the fee. Payment types accepted are cash, check or RevTrak (online payments)</p>

Clearance will be issued after all items listed and your fee or waiver has been submitted. Report to the coach with the clearance. No participation will be allowed until clearance has been given to the coach. Clearance must be requested (and the fee paid) at the beginning of each sport season in which the student participates. (Check with your school office for specific school variations to this procedure.)

PART A PARENT PERMIT FOR ATHLETIC PARTICIPATION

Student Name _____ Grade _____

Warning: Although participation in supervised interscholastic athletics and activities may be one of the least hazardous in which the student will engage in or out of school, BY ITS NATURE, PARTICIPATION IN INTERSCHOLASTIC ATHLETICS INCLUDES A RISK OF INJURY, WHICH MAY RANGE IN SEVERITY FROM MINOR TO LONG-TERM CATASTROPHIC INJURY OR DEATH. Although serious injuries are not common in supervised school athletic programs, it is impossible to eliminate this risk.

PLAYERS MUST OBEY ALL SAFETY RULES, REPORT TO THEIR COACHES, FOLLOW A PROPER CONDITIONING PROGRAM, AND INSPECT AND USE THEIR OWN EQUIPMENT DAILY.

The Thompson School District generally provides district transportation for students to and from a great many activities, events, matches and games. However, the district is unable to provide district transportation in all circumstances and to all events or activities. When district transportation is not available, it is the student's parent's or guardian's responsibility to provide or arrange for their student's transportation to and from the event.

By signing this permit for athletic participation, we acknowledge that we have read and understood this warning. PARENTS OR STUDENTS WHO DO NOT WISH TO ACCEPT THE RISKS DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS PERMISSION FORM.

I HEREBY GIVE MY CONSENT FOR THE ABOVE NAMED STUDENT TO, (1) represent his/her school in approved athletic activities except those indicated on the physician's statement form; (2) accompany any school team of which he/she is a member on its local or out-of-town trips; (3) receive, through a medical doctor, emergency medical technician, coach or certified athletic trainer of the school's choice, emergency medical care which may become reasonably necessary in the course of such athletic activities or such travel. I understand that the cost of such medical care is my responsibility. I further agree not to hold the school, or anyone acting in its behalf, responsible for any injury occurring to the student in the proper course of such athletic activities or travel.

DATE _____ PARENT'S/GUARDIAN SIGNATURE

In compliance with school district policy, every student participating in an organized athletic program must be covered by appropriate medical/accident insurance and a release of liability by the parent or guardian for any injury or accident which may occur while participating in such programs. I agree to keep such insurance in force and effect; and I hereby assume full and complete financial responsibility relative to any injury or accident that occurs while participating in the athletic program, or traveling to and from such a program. **I HEREBY CERTIFY THAT THE ABOVE NAMED STUDENT HAS THE FOLLOWING INSURANCE COVERAGE:**

NAME OF INSURANCE _____ POLICY NUMBER _____

(If family medical insurance is not available, the student must purchase school-time medical insurance.) Information on this plan is available at the District Office Insurance Department.

Part B

SIGNATURE PAGE

ACKNOWLEDGMENT FOR CODE OF CONDUCT, TRAINING RULES AND STANDARDS FOR COMMUNICATION

The following signatures indicate that both the parent and student-athlete have read the Thompson School District Standards for Communication - Athletics and Activities Handbook and the athletic training/conduct rules located online and **agree to the terms, stipulations and understand that this document is effective until the athlete's graduation:**

Parent/Guardian Signature: _____

Date: _____

Student/Athlete Signature: _____

Date: _____

Grade: _____

HEALTH INFORMATION

I give ___ do not give ___ permission for health information to be shared with adults in the school setting that will be working with my child during the current school year.

Date: _____ Parent/Guardian Signature: _____

CONSENT FOR RELEASE OF INFORMATION TO ACCESS MEDICAID REIMBURSEMENT FOR HEALTH-RELATED SUPPORT SERVICES

Is your child eligible for Medicaid? Yes ___ No ___

If yes, please provide Medicaid number _____ - _____ - _____

Date: _____ Parent/Guardian Signature: _____

STUDENT ELIGIBILITY INFORMATION

I hereby give my consent for _____ to compete in athletics for Mountain View High School in Colorado High School Activities Association approved sports, except as noted on the Physical Examination and Parent Permit Form, and I have read and understand the general guidelines for eligibility as outlined in the *CHSAA Competitor's Brochure* (as found on the CHSAA site).

Parent or Guardian Signature _____ Date _____

I have read, understand and agree to the General Eligibility Guidelines as outlined in the *CHSAA Competitor's Brochure*.

Student Signature _____ Date _____

No student shall represent their school in interschool athletics until there is a statement on file with the superintendent or principal signed by his/her parent or legal guardian and a signed physical form certifying that he/she has passed an adequate physical examination within the past year. Noting that in the opinion of the examining physician, physician's assistant, nurse practitioner or a certified/registered chiropractor, is physically fit to participate in high school athletics; that student has the consent of his/her parents or legal guardian to participate; and, the parent and participant have read, understand and agree to the CHSAA guidelines for eligibility.

Part C History Physical Examination

Date _____ Personal Physician _____

Name _____ Sex ____ Age ____ Date of Birth _____

Explain "Yes" answers below:

- Have you ever been hospitalized? Yes No
- Have you ever had surgery? Yes No
- Are you presently taking any medications or pills? Yes No
- Do you have any allergies (medicine, bees, or other stinging insects)? Yes No
- Have you ever passed out during or after exercise? Yes No
- Have you ever been dizzy during or after exercise? Yes No
- Have your ever had chest pain during or after exercise? Yes No
- Do you tire more quickly than your friends during exercise? No Yes
- Have you ever had high blood pressure? Yes No
- Have you ever been told that you have a heart murmur? Yes No
- Have you ever had racing of your heart or skipped heartbeats? Yes No
- Has anyone in you family died of heart problems or a sudden death before age 50? Yes No
- Do you have any skin problems (itching, rashes, acne)? Yes No
- Have you ever had a head injury? Yes No
- Have you ever been knocked out or unconscious? Yes No
- Have you ever had a seizure? Yes No
- Have you ever had a stinger, burner or pinched nerve? Yes No
- Have you ever had heat or muscle cramps? Yes No
- Have you ever been dizzy or passed out in the heat? Yes No
- Do you have trouble breathing or do you cough during or after activity? No Yes
- Do you use any special equipment (pads, braces, neck rolls, mouth guard eye guard, etc.)? Yes No
- Have you had any problems with your eyes or vision? Yes No
- Do you wear glasses or contacts or protective eye wear? Yes No
- Have you ever sprained/strained, dislocated, fractured, broken or had repeated or other injuries of any bones or joints? Yes No
- [] Head [] Shoulder [] Thigh [] Neck [] Elbow [] Knee [] Chest [] Foot
- [] Forearm [] Shin/calf [] Back [] Wrist [] Ankle [] Hip [] Hand
- Have you had any other medical problems (infectious mononucleosis diabetes, etc.) Yes No
- Have you had a medical problem or injury since your last evaluation? Yes No
- When was your last tetanus shot? _____
- When was your last measles immunization? _____
- When was your first menstrual period? _____
- When was your last menstrual period? _____
- What was the longest time between your periods last year? _____

Explain "yes" answers:

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

Date: _____

Signature of athlete: _____

Signature of parent/guardian: _____

LIMITED	Height _____ Weight _____ BP _____ / _____ Pulse _____ G	
	Vision R 20/ _____ L 20/ _____ Corrected: Y N Pupils _____ G	
	Normal Abnormal Findings Initials	
	Cardiopulmonary	
	Pulses	
	Heart	
	Lungs	
	Tanner stage	1 2 3 4 5
	Skin	
	COMPLETE	Abdominal
Genitalia		
Musculoskeletal		
Neck		
Shoulder		
Elbow		
Wrist		
Hand		
Back		
Knee		
Ankle		
Foot		
Other		

CLEARANCE

- A. Cleared
- B. Cleared after completing evaluation/rehabilitation for: _____
- C. Not cleared for collision contact non-contact ___ strenuous ___ moderately strenuous ___ non strenuous

RECOMMENDATIONS: _____

NAME OF PHYSICIAN/ PA/ NURSE PRACTITIONER/ CERTIFIED-REGISTERED CHIROPRACTOR: _____

ADDRESS _____ PHONE _____

SIGNATURE OF MD/DO,PA/NA,DC-SPC# _____

DATE: _____



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MEDICAL INFORMATION CARD

HIGH SCHOOL
STUDENT-ATHLETE MEDICAL INFORMATION

General Information (Please Print)

Student Name: _____ Sport: _____
Age: _____ Grade: _____ Birth Date: _____ SS# _____
Parent/Guardian(s) Name: _____
Address: _____
Phone: day: _____ night: _____ cell: _____
Other authorized persons to contact in emergency:
Name: _____ Phone: _____
Name: _____ Phone: _____
Hospital Preference: _____ Insurance Co. _____
Policy #: _____ Group #: _____ Phone #: _____

Medical

Information

Medical Illnesses: _____
Last tetanus booster shot (mo/yr): _____ Allergies: _____
Medications: _____
(any medications possible needed to be taken during competition require a physician's note)
Previous head/neck or back injury: _____
Previous heat-related problems: _____
Other information necessary to inform medical staff: _____

Consent for Athletic Conditioning, Training and Health Care Procedures

I hereby give consent for my child to participate in the school's athletic conditioning and training program and to receive any necessary treatment, including first aid, diagnostic procedures and medical treatment, that may be provided by treating physicians, nurses and other healthcare providers including OCR Athletic Trainers and OCR physicians. OCR has my permission to release athletic injury information about my child to the school. In the event I cannot be reached in an emergency, I hereby give permission for my child to be transported to receive necessary treatment. I understand that OCR does research in the prevention of the athletic injuries and use generalized information that does not personally identify the individual student. OCR may use this generalized information that does not identify my child in such research.

Parent or Guardian Signature _____ Date: _____

This card is valid from August 1, 2014 - July 31, 2015.

Note: If any changes in the above information occur, a new card must be completed by the parent

Part D ATHLETIC INJURY EMERGENCY INFORMATION

Athlete _____ Sport _____

Birthdate _____ Grade _____ Height _____ Weight _____

Parent/Guardian _____ Cell Phone _____

Address _____ Home Phone _____

Email Address _____

Other Emergency Contact _____ Cell Phone _____

Family Physician _____ Phone _____

Name of Insurance Company _____ Policy Number _____

I hereby give permission for the coach or other school official to arrange for emergency treatment for the above named student with a physician, EMT, certified athletic trainer or hospital emergency room in the event that I cannot be notified. I understand that the school does not carry insurance for any loss that may be sustained due to injury as a result of athletic participation.

_____ Date _____
Parent or Guardian

The following information may be needed to insure proper responses in certain situations. Please complete accurately.

1. Known allergies and medications:

<u>Allergy</u>	<u>Medications/Dosage Being Taken</u>
_____	_____
_____	_____

2. Other Medications/Dosages Being Taken:

3. Known medical conditions (check if applicable and add others):

____ Diabetes ____ Seizure Disorder ____ Asthma
____ Other _____

4. History of significant old injury (what, where, when?)

5. Date of last tetanus inoculation: Month _____ Year _____