2015-2016 **Authorization to Consent to Treatment of a Minor** **S-01**

Student's Name_____ Birthdate:_____/_____/_____ Student ID#:_____
Print (Last),(First)(Middle (Mo) (Day) (Yr)

Sex: (circle one) M F Grade Level:_____ Sport_____

Home address:_____ Zip:_____

Home phone w/area code:_____

Father's name:_____ Business/Cell phone:_____

Mother's name_____ Business/Cell phone:_____

List another person to be notified in case of emergency if parents are not available:

1._____ Relationship:_____

Home phone:_____ Business/Cell phone:_____

Special Medical Conditions to be noted (i.e. Allergies, Medications, Disorders)_____

(I)(We), the undersigned, parent(s) do hereby authorize any official of Spring Branch Independent School District to act as designee for the above named minor to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is prescribed by, and is to be rendered under the special supervision of, any licensed physician/or surgeon, whether such diagnosis or treatment is rendered at the office of said physician/or surgeon or at a hospital or elsewhere.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being rendered and is given to provide authority and power on the part of our aforesaid designee to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician/surgeon may, for reasons he/she deems appropriate, prescribe.

(I)(We), hereby authorize any hospital which has provided treatment to the above named minor to surrender physical custody of such minor to (my)(our) named designee(s) upon completion of treatment. This authorization is given for designee(s) for those times that (I)(We) cannot be reached by telephone at home or work at the numbers listed below.

This authorization is not to be construed as releasing any physician or surgeon from any requirement that he or she adhere to the lawful standard of care in attending to the named minor and is not to be construed as creating any financial responsibility on the part of the Spring Branch Independent School District or the named officials thereof for any health care provided the named minor. PARENTS ARE RESPONSIBLE FOR PAYMENT.

This authorization shall become effective as of_____ 2015 and remain effective until_____ 2016.

Signature of Parent or Legal Guardian: _____

Insurance Information

Insurance information is required. Please provide a photocopy of your insurance I.D. Card.

Insurance Company Name:_____

Policy Number:_____ **Group Number:**_____

Name on Policy:_____

For Office Use Only: SBISD Ins.?	**Yes**	**No**

PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

REVISED 12-4-14

This **MEDICAL HISTORY FORM** must be completed ***annually*** by parent (or guardian) and student in order for the student to participate in athletic activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an athletic event.

Student's Name: (print) _____ Sex _____ Age _____ Date of Birth _____

Address _____ Phone _____

Grade _____ School _____

Personal Physician _____ Phone _____

In case of emergency, contact:

Name _____ Relationship _____ Phone (H) _____ (W) _____

Explain "Yes" answers in the box below**. Circle questions you don't know the answers to.

		Yes	No
1.	Have you had a medical illness or injury since your last check up or sports physical?	☐	☐
2.	Have you been hospitalized overnight in the past year?	☐	☐
	Have you ever had surgery?	☐	☐
3.	Have you ever had prior testing for the heart ordered by a physician?	☐	☐
	Have you ever passed out during or after exercise?	☐	☐
	Have you ever had chest pain during or after exercise?	☐	☐
	Do you get tired more quickly than your friends do during exercise?	☐	☐
	Have you ever had racing of your heart or skipped heartbeats?	☐	☐
	Have you had high blood pressure or high cholesterol?	☐	☐
	Have you ever been told you have a heart murmur?	☐	☐
	Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	☐	☐
	Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome or other ion channelpathy (Brugada syndrome, etc), Marfan's syndrome, or abnormal heart rhythm?	☐	☐
	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	☐	☐
	Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
4.	Have you ever had a head injury or concussion?	☐	☐
	Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐
	If yes, how many times? _____		
	When was your last concussion? _____		
	How severe was each one? (Explain below)		
	Have you ever had a seizure?	☐	☐
	Do you have frequent or severe headaches?	☐	☐
	Have you ever had numbness or tingling in your arms, hands, legs or feet?	☐	☐
	Have you ever had a stinger, burner, or pinched nerve?	☐	☐
5.	Are you missing any paired organs?	☐	☐
6.	Are you under a doctor's care?	☐	☐
7.	Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	☐	☐
8.	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	☐	☐
9.	Have you ever been dizzy during or after exercise?	☐	☐
10.	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	☐	☐
11.	Have you ever become ill from exercising in the heat?	☐	☐
12.	Have you had any problems with your eyes or vision?	☐	☐

		Yes	No
13.	Have you ever gotten unexpectedly short of breath with exercise?	☐	☐
	Do you have asthma?	☐	☐
	Do you have seasonal allergies that require medical treatment?	☐	☐
14.	Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	☐	☐
15.	Have you ever had a sprain, strain, or swelling after injury?	☐	☐
	Have you broken or fractured any bones or dislocated any joints?	☐	☐
	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	☐	☐

If yes, check appropriate box and explain below:

☐ Head	☐ Elbow	☐ Hip
☐ Neck	☐ Forearm	☐ Thigh
☐ Back	☐ Wrist	☐ Knee
☐ Chest	☐ Hand	☐ Shin/Calf
☐ Shoulder	☐ Finger	☐ Ankle
☐ Upper Arm	☐ Foot	

16.	Do you want to weight more or less than you do now?	☐	☐
17.	Do you feel stressed out?	☐	☐
18.	Have you ever been diagnosed with or treated for sickle cell trait or cell disease?	☐	☐

Females only

19. When was your first menstrual period? _____

When was your most recent menstrual period? _____

How much time do you usually have from the start of one period to the start of another? _____

How many periods have you had in the last year? _____

What was the longest time between periods in the last year? _____

An individual answering in the affirmative to any question relating to a possible cardiovascular health issue (question three above), as identified on the form, should be restricted from further participation until the individual is examined and cleared by a physician, physician assistant, chiropractor, or nurse practitioner.

**EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary):

_____

_____

_____

It is understood that even though protective equipment is worn by the athlete, whenever needed, the possibility of an accident still remains. Neither the University Interscholastic League nor the school assumes any responsibility in case an accident occurs.

If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student.

If, between this date and the beginning of athletic competition, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide truthful responses could subject the student in question to penalties determined by the UIL

Student Signature: _____ Parent/Guardian Signature: _____ Date: _____

Any Yes answer to questions 1, 2, 3, 4, 5, or 6 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physician assistant, chiropractor, or nurse practitioner is required before any participation in UIL practices, games or matches. THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE OR CONTEST BEFORE, DURING OR AFTER SCHOOL.

For School Use Only:

This Medical History Form was reviewed by: Printed Name _____ Date _____ Signature _____

PREPARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAMINATION

Student's Name _____ Sex _____ Age _____ Date of Birth_____

Height _____ Weight_____ % Body fat (optional) _____ Pulse _____ BP____/____ (____/____, ____/____)
brachial blood pressure while sitting

Vision: R 20/_____ L 20/___ Corrected: ☐ Y ☐ N Pupils: ☐ Equal ☐ Unequal

As a minimum requirement, this **Physical Examination Form** must be completed prior to junior high athletic participation and again prior to first and third years of high school athletic participation. It ***must*** be completed if there are yes answers to specific questions on the student's MEDICAL HISTORY FORM on the reverse side. **** Local district policy may require an annual physical exam.***

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in the supine position.			
Heart-Auscultation of the heart in the standing position.			
Heart-Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*station-based examination only

CLEARANCE

☐ Cleared

☐ Cleared after completing evaluation/rehabilitation for: _____

_____

☐ Not cleared for:_____Reason: _____

Recommendations: _____

_____

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner, will not be accepted.

Name (print/type) _____ Date of Examination: _____

Address: _____

Phone Number: _____

Signature: _____

Must be completed before a student participates in any practice, before, during or after school, (both in-season and out-of-season) or games/matches.

Spring Branch ISD

Authorization for the Release of Medical Information (FERPA)

The Family Education Right to Privacy Act (FERPA) is a federal law that governs the release of a student's educational records, including personal identifiable information (name, address, social security number, etc.) from those records. Medical information is considered a part of a student athlete's educational record.

This authorization permits physicians to disclose information concerning my medical status, medical condition, injuries, prognosis, diagnosis, and related personal identifiable health information to the authorized parties as follows: the licensed athletic trainers, team physicians, and athletic staff (including coaches) of Spring Branch ISD. This information includes injuries or illnesses relevant to past, present, or future participation in athletics.

The purpose of a disclosure is to inform authorized parties of the nature, diagnosis, prognosis or treatment concerning my medical condition and any injuries or illnesses. I understand once the information is disclosed it is subject to re-disclosure and is no longer protected.

I understand that Spring Branch ISD will not receive compensation for its disclosure of the information. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I may inspect or copy any information disclosed under this authorization.

I understand that I may revoke this authorization at any time by providing written notification to the head athletic trainer at the respective high school. Should I choose to revoke this authorization, I understand that I must present the SBISD licensed athletic trainer with documentation provided by the doctor mandating his/her directions regarding care or discharge. I understand revocation will not have any effect on actions Spring Branch ISD had taken in reliance on this authorization prior to receiving the revocation. This authorization expires at the conclusion of each school year.

Student ID#_____

Printed Name of Student:_____

Student Signature:_____

Printed Name of Parent:_____

Parent Signature:_____ Date:_____

SPRING BRANCH INDEPENDENT SCHOOL DISTRICT

District Athletic-U.I.L. Accident Insurance Plan

The Spring Branch Independent School District has purchased a limited benefit insurance policy that covers all student athletes while participating in, practicing, or traveling for athletic-UIL competition. The District is asking each individual who participates in the athletic-UIL insurance plan to pay a portion of the cost. For the 2015-2016 school year this cost is only $25.00.

The athletic insurance is not a 24 hour accident insurance.
(If you need additional accident coverage for your student, a limited benefit plan may be purchased through a school student insurance plan (see the brochure you received from your child's school) that will provide limited benefits for the student when he/she is not participating in athletic-U.I.L. events.)

The following information concerns the District's Athletic-U.I.L. coverage:

1. The cost of the policy to the student is only **$25.00.** Make checks payable to **S.B.I.S.D.**
2. This policy covers the student/athlete only during regular practice, off season practice, games during their season and when involved in an activity sanctioned by the U.I.L.
3. If you have other accident insurance for the student/athlete this policy becomes a secondary excess coverage policy and will be coordinated with any personal coverage that you may have. It will become the primary coverage if there is no other personal coverage available.

The Athletic/U.I.L. competition insurance is a Limited Benefit Plan. It will not pay 100% of the bills.
(A copy of the policy benefits can be obtained by calling the Central Athletic Office at 713-251-1207.
As an additional feature the policy also offers a "Network" of providers (physicians, X-rays, etc.) that will take most benefits on full assignment with little or no cost to you. *(Contact the head trainer at each high school or The Brokerage Store at 1-800-366-4810 for more information on the "Network").*

4. Any bills not paid by your personal carrier or the athletic-UIL policy will be the responsibility of the parents/guardians. **Parents/Guardians are responsible for filing any claims and any subsequent bills.**
5. If you have other insurance coverage, you **must** file with your personal insurance carrier first. If you are insured by an HMO/PPO, you must use the HMO/PPO facilities/doctors as specified by your insurance plan.
6. Except in an emergency, injuries should be reported to the campus athletic trainer or coach and a claim form should be obtained **before going to the doctor.**
7. Claim forms are available from the campus athletic trainer, campus athletic coordinator, or from the office of the District Athletic Office 713-251-1207.
8. A claim form will **not** be accepted by the insurance company if **Part A** is not filled out completely by the school trainer or the coach who witnessed the accident. Please read all instructions carefully.
9. **Please keep this information for your records.**

S-02information letter

MEDICAL BENEFITS (What the Insurance Plan Pays) - When injury covered by this policy results in treatment by a licensed physician within 180 days from the date of injury, the Company will pay the usual and customary (U&C) charges incurred for necessary services and supplies as listed below, for expenses actually incurred within one year from the date of injury up to a Maximum Medical Benefit of $25,000 per injury. This policy will pay benefits regardless of Other Valid Coverage. Unless otherwise stated all amounts listed below are per injury.

A.	**IN-PATIENT BENEFITS**	**All Amounts Listed Below are Per Injury**
1.	Hospital Room and Board	Semi-private Room Charges
2.	Intensive Care (in lieu of Hospital Room and Board)	1.5 X Semi-private Room Charges
3.	Hospital Miscellaneous Services (All Charges except Room & Board)	U&C, first day up to $1,000, then up to $500 per day; maximum $5,000
4.	Physician's Non-Surgical Visits (does not include Physical Therapy; not paid day of surgery)	U&C, first day of treatment up to $50, subsequent visits up to $40; maximum 10 visits
5.	Physical Therapy Treatment (includes whirlpool, diathermy, EMS, massage, manipulation or adjustments in any form, and/or office visits connected therewith)	Included in Hospital Misc. Benefit
6.	X-ray and Radiology Services	Included in Hospital Misc. Benefit
7.	Registered Nurse	U&C
B.	**OUT-PATIENT SURGERY BENEFITS**	
1.	Day Surgery (Facility Charge), room supplies and all other expenses for out-patient surgery	U&C, up to $2,000
C.	**OTHER OUT-PATIENT BENEFITS**	
1.	Hospital Emergency Room Charges	U&C, up to $300
2.	X-ray and Radiology Services	U&C; up to $250 Facility; $50 Reading
3.	CAT Scans, MRI and Bone Scans	U&C; up to $750 Facility; $50 Reading
4.	Laboratory Services	U&C, up to $100
5.	Physician's Non-Surgical Visits (not paid day of surgery)	U&C, up to $50 per visit; 10 visit maximum
6.	Emergency Room Physician's Non-Surgical Care	U&C, up to $150
7.	Orthopedic Appliances (when prescribed by a physician for healing)	U&C, up to $500
8.	Shots and Injections (within 24 hours of an injury)	U&C, up to $50
9.	Prescription Drugs	U&C, up to $50
10.	Physical Therapy Treatment (includes whirlpool, diathermy, EMS, massage, manipulation or adjustments in any form, and/or office visits)	U&C, up to $50 per visit; maximum 5 visits
11.	Ambulance Service (Air or Ground)	U&C, up to $1,000
12.	Eyeglass Replacement (if medical treatment is also received for a covered injury)	U&C, up to $200
13.	Durable Medical Equipment (Post-Surgical Only)	U&C, up to $100
D.	**OTHER PHYSICIAN SERVICES**	
1.	Dental Treatment (in lieu of all other medical benefits, including x-rays of sound & natural teeth)	U&C, up to $200 per tooth
2.	Physician's Surgical Care (In-Patient or Out-patient) Only one procedure will be allowed (the highest scheduled) when multiple procedures are performed through the same incision or in immediate succession	U&C up to $2,500
3.	Assistant Surgeon Charges (In-Patient or Out-patient)	25% of Surgery Allowance
4.	Anesthetist Charges (In-Patient or Out-patient)	25% of Surgery Allowance
E.	**MOTOR VEHICLE INJURY**	Same as any Injury, up to $1,000
F.	**OTHER BENEFITS -** Heat Stroke and Heat Exhaustion will be covered as any other accident.	
G.	**ACCIDENTAL DEATH AND DISMEMBERMENT**	

When injury covered by this policy results in Accidental Death or Dismemberment within 180 days from the date of accident, the following benefits would be payable.

Loss of Life	$2,000	Double Dismemberment	$10,000
Loss of an Eye	$2,000	Single Dismemberment	$ 2,000

EXCLUSIONS (What the Plan DOES NOT Pay)

1. Any sickness, disease, infection (unless caused by an open cut or wound), including but not limited to: aggravation of a congenital condition, blisters, headaches, hernia of any kind, mental or physi- cal infirmity, Osgood-Schlatter disease, osteochondritis, osteochondritis dissecans, osteomyelitis, spondylolysis, slipped femoral capital epiphysis, orthodontics.
2. Injuries for which benefits are payable under Workers' Compensation or Employer's Liability Laws.
3. Any Injury involving a two or three-wheeled motor vehicle or snowmobile or any motorized or engine driven vehicle not designed primarily for use on public streets and highways, unless the insured is participating in an activity sponsored by the Policyholder.
4. Replacement of contact lenses, hearing aids or prescriptions or examinations thereof.
5. The participation, practice or play of UIL activities including travel to or from such activity, practice, or play for students in the 7th grade or above, unless such premium is paid.

THE POLICY CONTAINS A PROVISION LIMITING COVERAGE TO USUAL AND CUSTOMARY CHARGES. THIS LIMITATION MAY RESULT IN ADDITIONAL OUT-OF-POCKET EXPENSES FOR THE INSURED.

SPRING BRANCH INDEPENDENT SCHOOL DISTRICT

District Athletic-U.I.L. Accident Insurance Plan

Student Name: (Please Print) -_____
(last) (first)

Student ID#: -_____

School: (Please Print) -_____

I have read the information presented on the District Athletic-UIL Accident Insurance on the "S-02 Information" page. I agree to participate in the District's Athletic-UIL accident insurance plan. I agree to pay $25.00 to join this coverage. I understand this is a limited benefit insurance policy that covers all student athletes while participating in, practicing, or traveling for athletic-UIL competition. I understand Parents/Guardians are responsible for filing any claims and paying any subsequent bills not paid by the insurance company. See Information page.

If you wish to not participate in the insurance program, please contact your coach or trainer to obtain a "Refusal of Insurance" form to sign and return.

(Acceptance)

**** **A.** Signature of Parent/Guardian_____ Date_____

SPRING BRANCH INDEPENDENT SCHOOL DISTRICT

District Athletic-U.I.L. Accident Insurance Plan

Student Name: (Please Print) -_____
(last) (first)

School: (Please Print) -_____

It is the policy of the Spring Branch Independent School District to require every student/athlete participating in school sponsored athletic programs to be covered by accident insurance. The District will not allow any child to participate in these activities until the parent or guardian has purchased the District's Athletic/U.I.L. accident insurance or has certified that the student already is covered by an accident policy offering equivalent or greater coverage than the District's Athletic/U.I.L. accident insurance plan.

REFUSAL OF DISTRICT ATHLETIC-UIL ACCIDENT INSURANCE

I understand that it is a policy of the Spring Branch Independent School District to require that every child participating in middle school or senior high school athletics to be covered by accident insurance. The District will not allow any child to participate in such activities until the parent or guardian has purchased athletic/UIL accident insurance offered under the District's Student Accident Insurance Plan, or has certified that he already has a policy of accident insurance providing substantially the same protection as provided under the District's Student Accident Insurance Plan.

I, or my insurance agent, have checked my accident insurance policy against the policy provided under the District's Student Accident Insurance Plan and I certify that coverage afforded under my policy for protection against accidental injury to such child while participating in athletics is substantially the same as that provided under the District's Student Accident Insurance Plan.

I further understand that all claims arising out of accidental injury to such child are to be presented to and paid by my personal accident insurance carrier and are not to be presented, processed through, or paid by the carrier under the District's Athletic-UIL Accident Insurance Plan.

Signature at this point signifies that I decline participation in the District's Student Accident Insurance Plan for athletic/UIL coverage.

Proof of current insurance coverage must be provided: a photocopy of the current insurance I.D. card and the current accident insurance information must also be recorded on the "Authorization For Consent To Treatment Of A Minor" form (S-01).

(Refusal)
****** R.** Signature of Parent/Guardian_____ Date_____

ACKNOWLEDGEMENT OF RULES

Attention School Authorities: This form must be signed yearly by both the student and parent/guardian and be on file at your school before the student may participate in any practice session, scrimmage, or contest. A copy of the student's medical history and physical examination form signed by a physician or medical history form signed by a parent must also be on file at your school.

Student's Name _____Date of Birth _____
Current School _____

Parent or Guardian's Permit

I hereby give my consent for the above student to compete in University Interscholastic League approved sports, and travel with the coach or other representative of the school on any trips.

It is understood that even though protective equipment is worn by the athlete whenever needed, the possibility of an accident still remains. Neither the University Interscholastic League nor the high school assumes any responsibility in case an accident occurs.

I have read and understand the University Interscholastic League rules on the reverse side of this form and agree that my son/daughter will abide by all of the University Interscholastic League rules.

The undersigned agrees to be responsible for the safe return of all athletic equipment issued by the school to the above named student.

If, in the judgement of any representatives of the school, the above student needs immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given to said student by any physician, licensed athletic trainer, nurse, hospital, or school representative; and I do hereby agree to indemnify and save harmless the school and any school representative from any claim by any person whomsoever on account of such care and treatment of said student.

I have been provided the UIL Parent Information Manual regarding health and safety issues including concussions and my responsibilities as a parent/guardian. I understand that failure to provide accurate and truthful information on UIL forms could subject the student in question to penalties determined by the UIL.

The UIL Parent Information Manual is located at www.uiltexas.org/files/athletics/manuals/parent-information-manual.pdf.

Your signature below gives authorization that is necessary for the school district, its licensed athletic trainers, coaches, associated physicians andstudent insurance personnel to share information concerning medical diagnosis and treatment for your student.

To the Parent: Check any activity in which this student is allowed to participate.

☐ Baseball	☐ Football	☐ Softball	☐ Tennis
☐ Basketball	☐ Golf	☐ Swimming & Diving	☐ Track & Field
☐ Cross Country	☐ Soccer	☐ Team Tennis	☐ Volleyball
☐ Wrestling			

Date_____
Signature of parent or guardian_____
Street address_____
City_____ State _____ Zip _____
Home Phone _____ Business Phone _____

GENERAL INFORMATION

School coaches may not:

- Transport, register, or instruct students in grades 7-12 from their attendance zone in non-school baseball, basketball, football, soccer, softball, or volleyball camps (exception: See Section 1209 of the Constitution and Contest Rules).
- Give any instruction or schedule any practice for an individual or a team during the off-season except during the one in school day athleticperiod in baseball, basketball, football, soccer, softball, or volleyball
- Schools and school booster clubs may not provide funds, fees, or transportation for non-school activities.

GENERAL ELIGIBILITY RULES

According to UIL standards, students could be eligible to represent their school in interscholastic activities if they:

- are not 19 years of age or older on or before September 1 of the current scholastic year. (See Section 446 of the Constitution and Contest Rules for exception).
- have not graduated from high school.
- are enrolled by the sixth class day of the current school year or have been in attendance for fifteen calendar days immediately preceding a varsity contest.
- are full-time students in the participant high school they wish to represent.
- initially enrolled in the ninth grade not more than four years ago.
- are meeting academic standards required by state law.
- live with their parents inside the school district attendance zone their first year of attendance. (Parent residence applies to varsity athletic eligibility only.) When the parents do not reside inside the district attendance zone the student could be eligible if: the student has been in continuous attendance for at least one calendar year and has not enrolled at another school; no inducement is given to the student to attend the school (for example: students or their parents must pay their room and board when they do not live with a relative; students driving back into the district should pay their own transportation costs); and it is not a violation of local school or TEA policies for the student to continue attending the school. Students placed by the Texas Youth Commission are covered under Custodial Residence (see Section 442 of the Constitution and Contest Rules).
- have observed all provisions of the Awards Rule.
- have not been recruited. (Does not apply to college recruiting as permitted by rule.)
- have not violated any provision of the summer camp rule. Incoming 10-12 grade students shall not attend a baseball, basketball, football, soccer, or volleyball camp in which a seventh through twelfth grade coach from their school district attendance zone, works with, instructs, transports or registers that student in the camp. Students who will be in grades 7, 8, and 9 may attend one baseball, one basketball, one football, one soccer, one softball, and one volleyball camp in which a coach from their school district attendance zone is employed, for no more than six consecutive days each summer in each type of sports camp. Baseball, Basketball, Football, Soccer,Softball, and Volleyball camps where school personnel work with their own students may be held in May, after the last day of school, June, July and August prior to the second Monday in August. If such camps are sponsored by school district personnel, they must be heldwithin the boundaries of the school district and the superintendent or his designee shall approve the schedule of fees.
- have observed all provisions of the Athletic Amateur Rule. Students may not accept money or other valuable consideration (tangible or intangible property or service including anything that is usable, wearable, salable or consumable) for participating in any athletic sport during any part of the year. Athletes shall not receive valuable consideration for allowing their names to be used for the promotion of any product, plan or service. Students who inadvertently violate the amateur rule by accepting valuable consideration may regain athletic eligibility by returning the valuable consideration. If individuals return the valuable consideration within 30 days after they are informed of the rule violation, they regain their athletic eligibility when they return it. If they fail to return it within 30 days, they remain ineligible for one year from when they acceptedit. During the period of time from when students receive valuable consideration until they return it, they are ineligible for varsity athletic competition in the sport in which the violation occurred. Minimum penalty for participating in a contest while ineligible is forfeiture of the contest.
- did not change schools for athletic purposes.

I understand that failure to provide accurate and truthful information on UIL forms could subject the student in question to penalties determined by the UIL.

I have read the regulations cited above and agree to follow the rules.

_____ _____

Date Signature of student

University Interscholastic League

Parent and Student Agreement/Acknowledgement Form
Anabolic Steroid Use and Random Steroid Testing

- Texas state law prohibits possessing, dispensing, delivering or administering a steroid in a manner not allowed by state law.
- Texas state law also provides that body building, muscle enhancement or the increase in muscle bulk or strength through the use of a steroid by a person who is in good health is not a valid medical purpose.
- Texas state law requires that only a licensed practitioner with prescriptive authority may prescribe a steroid for a person.
- Any violation of state law concerning steroids is a criminal offense punishable by confinement in jail or imprisonment in the Texas Department of Criminal Justice.

STUDENT ACKNOWLEDGEMENT AND AGREEMENT

As a prerequisite to participation in UIL athletic activities, I agree that I will not use anabolic steroids as defined in the UIL Anabolic Steroid Testing Program Protocol. I have read this form and understand that I may be asked to submit to testing for the presence of anabolic steroids in my body, and I do hereby agree to submit to such testing and analysis by a certified laboratory. I further understand and agree that the results of the steroid testing may be provided to certain individuals in my high school as specified in the UIL Anabolic Steroid Testing Program Protocol which is available on the UIL website at www.uiltexas.org. I understand and agree that the results of steroid testing will be held confidential to the extent required by law. I understand that failure to provide accurate and truthful information could subject me to penalties as determined by UIL.

Student Name (Print): _____ Grade (9-12) _____

Student Signature: _____ Date: _____

PARENT/GUARDIAN CERTIFICATION AND ACKNOWLEDGEMENT

As a prerequisite to participation by my student in UIL athletic activities, I certify and acknowledge that I have read this form and understand that my student must refrain from anabolic steroid use and may be asked to submit to testing for the presence of anabolic steroids in his/her body. I do hereby agree to submit my child to such testing and analysis by a certified laboratory. I further understand and agree that the results of the steroid testing may be provided to certain individuals in my student's high school as specified in the UIL Anabolic Steroid Testing Program Protocol which is available on the UIL website at www.uiltexas.org. I understand and agree that the results of steroid testing will be held confidential to the extent required by law. I understand that failure to provide accurate and truthful information could subject my student to penalties as determined by UIL.

Name (Print): _____

Signature: _____ Date: _____

Relationship to student: _____

CONCUSSION ACKNOWLEDGEMENT FORM

Name of Student _____

Definition of Concussion - means a complex pathophysiological process affecting the brain caused by a traumatic physical force or impact to the head or body, which may: (A) include temporary or prolonged altered brain function resulting in physical, cognitive, or emotional symptoms or altered sleep patterns; and (B) involve loss of consciousness.

Prevention – Teach and practice safe play & proper technique.
- Follow the rules of play.
- Make sure the required protective equipment is worn for all practices and games.
- Protective equipment must fit properly and be inspected on a regular basis.

Signs and Symptoms of Concussion – The signs and symptoms of concussion may include but are not limited to: Head ache, appears to be dazed or stunned, tinnitus (ringing in the ears), fatigue, slurred speech, nausea or vomiting, dizziness, loss of balance, blurry vision, sensitive to light or noise, feel foggy or groggy, memory loss, or confusion.

Oversight - Each district shall appoint and approve a Concussion Oversight Team (COT). The COT shall include at least one physician and an athletic trainer if one is employed by the school district. Other members may include: Advanced Practice Nurse, neuropsychologist or a physician's assistant. The COT is charged with developing the Return to Play protocol based on peer reviewed scientific evidence.

Treatment of Concussion - The student-athlete-af ccpjc_bcp shall be removed from practice or n_prgagn_tion immediately if suqtained a concussion. Every student-athlete-af ccpjc_bcp suspected of sustaining a concussion shall be seen by a physician before they may return to athletic mpaf ccpjc_bgl e participation. The treatment for concussion is cognitive rest. Students should limit external stimulation such as watching television, playing video games, sending text messages, use of computer, and bright lights. When all signs and symptoms of concussion have cleared and the student has received written clearance from a physician, the student-athlete-af ccpjc_bcp may begin their district's Return to Play protocol as determined by the Concussion Oversight Team.

Return to Play - According to the Texas Education Code, Section 38.157:
A student removed from an interscholastic athletics practice or competition &gl ajsagl e ncpS Gi psjc*af ccpjc_bgl e' under Section 38.156 may not be permitted to practice or n_prgagn_rc again following the force or impact believed to have caused the concussion until:
(1) the student has been evaluated, using established medical protocols based on peer-reviewed scientific evidence, by a treating physician chosen by the student or the student 's parent or guardian or another person with legal authority to make medical decisions for the student;
(2) the student has successfully completed each requirement of the return-to-play protocol established under Section 38.153 necessary for the student to return to play;
(3) the treating physician has provided a written statement indicating that, in the physician 's professional judgment, it is safe for the student to return to play; and
(4) the student and the student 's parent or guardian or another person with legal authority to make medical decisions for the student:
(A) have acknowledged that the student has completed the requirements of the return-to-play protocol necessary for the student to return to play;
(B) have provided the treating physician 's written statement under Subdivision (3) to the person responsible for compliance with the return-to-play protocol under Subsection (c) and the person who has supervisory responsibilities under Subsection (c); and
(C) have signed a consent form indicating that the person signing:
(i) has been informed concerning and consents to the student participating in returning to play in accordance with the return-to-play protocol;
(ii) understands the risks associated with the student returning to play and will comply with any ongoing requirements in the return-to-play protocol;
(iii) consents to the disclosure to appropriate persons, consistent with the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191), of the treating physician 's written statement under Subdivision (3) and, if any, the return-to-play recommendations of the treating physician; and
(iv) understands the immunity provisions under Section 38.159.

_____ _____

Parent or Guardian Signature *Date*

_____ _____

Student Signature *Date*

SUDDEN CARDIAC ARREST AWARENESS FORM

Revised February 2015

Name of Student: _____

What is Sudden Cardiac Arrest?

- Occurs suddenly and often without warning.
- An electrical malfunction (short-circuit) causes the bottom chambers of the heart (ventricles) to beat dangerously fast (ventricular tachycardia or fibrillation) and disrupts the pumping ability of the heart.
- The heart cannot pump blood to the brain, lungs and other organs of the body.
- The person loses consciousness (passes out) and has no pulse.
- Death occurs within minutes if not treated immediately.

What causes Sudden Cardiac Arrest?

- **Conditions present at birth**
  - ***Inherited*** *(passed on from parents/relatives)* ***conditions of the heart muscle:***
    - **Hypertrophic Cardiomyopathy** – hypertrophy (thickening) of the left ventricle; the most common cause of sudden cardiac arrest in athletes in the U.S.
    - **Arrhythmogenic Right Ventricular Cardiomyopathy** – replacement of part of the right ventricle by fat and scar; the most common cause of sudden cardiac arrest in Italy.
    - **Marfan Syndrome** – a disorder of the structure of blood vessels that makes them prone to rupture; often associated with very long arms and unusually flexible joints.
  - ***Inherited conditions of the electrical system:***
    - **Long QT Syndrome** – abnormality in the ion channels (electrical system) of the heart.
    - **Catecholaminergic Polymorphic Ventricular Tachycardia and Brugada Syndrome –** other types of electrical abnormalities that are rare but run in families.
  - ***NonInherited*** *(not passed on from the family, but still present at birth)* ***conditions:***
    - **Coronary Artery Abnormalities** – abnormality of the blood vessels that supply blood to the heart muscle. The second most common cause of sudden cardiac arrest in athletes in the U.S.
    - **Aortic valve abnormalities** – failure of the aortic valve (the valve between the heart and the aorta) to develop properly; usually causes a loud heart murmur.
    - **Non-compaction Cardiomyopathy** – a condition where the heart muscle does not develop normally.
    - **Wolff-Parkinson-White Syndrome** –an extra conducting fiber is present in the heart's electrical system and can increase the risk of arrhythmias.
- **Conditions not present at birth but acquired later in life:**
    - **Commotio Cordis** – concussion of the heart that can occur from being hit in the chest by a ball, puck, or fist.
    - **Myocarditis** – infection/inflammation of the heart, usually caused by a virus.
    - **Recreational/Performance-Enhancing drug use**.
- **Idiopathic**: Sometimes the underlying cause of the Sudden Cardiac Arrest is unknown, even after autopsy.

SUDDEN CARDIAC ARREST AWARENESS FORM

Revised February 2015

What are the symptoms/warning signs of Sudden Cardiac Arrest?

- Fainting/blackouts (especially during exercise)
- Dizziness
- Unusual fatigue/weakness
- Chest pain
- Shortness of breath
- Nausea/vomiting
- Palpitations (heart is beating unusually fast or skipping beats)
- Family history of sudden cardiac arrest at age < 50

ANY of these symptoms/warning signs that occur while exercising may necessitate further evaluation from your physician before returning to practice or a game.

What is the treatment for Sudden Cardiac Arrest?

- Time is critical and an immediate response is vital.
- **CALL 911**
- **Begin CPR**
- **Use an Automated External Defibrillator (AED)**

What are ways to screen for Sudden Cardiac Arrest?

- The American Heart Association recommends a pre-participation history and physical including 14 important cardiac elements.
- **The UIL *Pre-Participation Physical Evaluation – Medical History* form includes ALL 14 of these important cardiac elements and is mandatory annually**.
- Additional screening using an electrocardiogram and/or an echocardiogram is readily available to all athletes, but is not mandatory.

Where can one find information on additional screening?

- The Cardiac section on the UIL Health and Safety website (uiltexas.org).

_____ _____

Parent/Guardian Signature Date

_____

Parent/Guardian Name (Print)

_____ _____

Student Signature Date

_____

Student Name (Print)

SPECIAL MEDICAL INFORMATION FORM

First Name Last Name Student ID

Do you have any allergies?

o Yes o No

Does this Allgery require an Epi-Pen?

o Yes o No

If you answer yes you are required to download and print this form and have your physician fill out and return it to your Athletic Trainer. Physician's Statement for Student Held EpiPen

Do you have Asthma?

o Yes o No

Does your Asthma require an inhaler?

o Yes o No

If you answer yes you are required to download and print this form and have your physician fill out and return it to your Athletic Trainer. Physician's Statement for Student Held Inhaler

Do you have Diabetes?

o Yes o No

Are you?

oType 1

o Type 2
o No Diabetes

If you check type 1 diabetes you are required to download and print this form and have your physician fill out and return it to your athletic trainer.
Physician's Authorization for Student Self-management of Diabetes

Please State Medication Used

Do you have any other Special Medical Conditions?

o Yes o No

Do you take or need any other Prescription Medications on daily Basis or for immediate care?

o Yes o No

Student Signature Date

Parent Signature Date