

Castro Valley High School Athletics
2014 - 2015
Athletic Packet Checklist

List of **Mandatory** forms to be submitted to the **FINANCE OFFICE**
prior to participation in athletics
(DO NOT GIVE THESE FORMS TO THE COACH):

- 1. Checklist
- 2. Athletic Department Locator & Clearance Form
- 3. Athletic Parent/Guardian Consent/Proof of Insurance
- 4. Sports Physical Form
- 5. Athlete/Parent Participation Information
- 6. Concussion Information Sheet
- 7. Athletic Transfer Screening Form
- 8. E Script Form (encouraged, but optional)

OPTIONAL forms to return to the **Main Office**:

- Transportation Authorization Form (Attach Insurance Coverage Declaration Page)
- Volunteer Clearance Form
- Megan's Law

Handbooks and Policies to review:

- The Student Handbook For Interscholastic Athletics and Co-curricular Activities
- The Non-Use Steroid Agreement/The Athletic Participation Agreement
- The CVUSD Athletics/Activities Code of Conduct Agreement
- The CVHS Athletic Student and Parent/Guardian Handbook

Castro Valley High School Athletics

19400 Santa Maria Ave, Castro Valley, California 94546 • 510-537-5910

FAX: 510-582-3924 • website: www.castrovalleyhigh.org

ATHLETIC DEPARTMENT LOCATOR & CLEARANCE

List the sports you intend to play: Fall _____ Winter _____ Spring _____
Year in School (*circle*) 9 10 11 12 Date of Birth _____
Last Name _____ First Name _____ Student ID _____
Address _____ Phone _____
Doctor's Name _____ Doctor's Phone _____
Mother's Name _____ Email: _____ Emergency Ph _____
Father's Name _____ Email: _____ Emergency Ph _____
Heath Plan Provider _____ Policy #: _____ Preferred Hosp: _____

PARENT/STUDENT CONSENT AND WAIVER OF LIABILITY

I hereby give my consent for the above named student to compete and participate in the Castro Valley Unified School District approved activity program referenced above and to travel with the school representative on authorized school trips, if applicable. I, the undersigned, hereby release and discharge the Castro Valley Unified School District, officers, employers, agents, servants and volunteers (herein collectively referred to as 'District') from all liability arising out of or in connection with the above described activity or all liabilities associated with any and all claims related to such activity that may be filed on behalf of or for the above named minor. For the purposes of this agreement, liability means all claims, demands, losses, causes of action, suits or judgments of any and every kind that occurs during the above described activity and that results from any cause including the active or passive conduct and/or negligence of the District.

I also acknowledge on my behalf and on the behalf of the above named minor that there are risks that are inherent in the above-described activity, including the risk of serious injury that may occur through the conduct of other participants, coaches, District, including conduct that may not be part of the ordinary risks of the activity itself. For example, injury may occur through conduct that is not authorized by the rules and regulations of the activity. This release and waiver as set forth in the above paragraph shall also apply to this type of conduct and any resulting injury. I give my permission for the named doctor to take full charge of the disposition of my son/daughter in case of injury and in the event school authorities are unable to contact parent. I (we) understand that any injury must be reported in writing to the coach responsible for the activity within five (5) days.

By initialing the following line, I hereby give consent for my son/daughter's photograph to appear on the school website and in other athletic-related publications. Initial to agree to photo release _____

I have carefully read this waiver and release of liability and fully understand its terms and condition and understand that by signing this document that I have given up substantial rights for the named minor and myself.

Parent/Guardian Signature Date Participants Signature Date

ATHLETIC DEPARTMENT POLICIES

The following policies must be read and understood before your child may participate in Castro Valley High School's Athletic Program. They are accessible online at www.castrovalleyhigh.org/athletics. (The forms are included in the Student/Parent Handbook under Athletic Department Policies.)

By initialing each line, I am declaring that I have read and understood all policies listed and agree to abide by them.

_____ CVUSD/CVHS Code of Conduct _____ CIF Steroid Policy
_____ WACC Ejection Policy _____ Reviewed Student/Parent Handbook
_____ WACC Sportsmanship Policy

We agree to abide by all regulations and expectations required by the Castro Valley Unified School District/Castro Valley High School Athletic Program and any rules set forth by individual coaches. We accept the consequences should any rule be violated.

Parent/Guardian Signature Date Participants Signature Date

FOR SCHOOL USE ONLY

INSURANCE:
 Football only
 Other Sports
 Dental
 Insurance Waiver

CLEARED FOR:
 Athletic Sport
 Athletic Field Trip

Physical (Date): _____

Administrator/Designee Approval Date



Castro Valley Unified School District

P.O. Box 2146
4400 Alma Ave.
Castro Valley, CA 94546

ATHLETIC PARENT/GUARDIAN CONSENT/PROOF OF INSURANCE

All sections of this form must be completed and turned in to the Finance Office BEFORE A STUDENT CAN BE ISSUED EQUIPMENT, PARTICIPATE IN PRACTICE, OR COMPETE IN CONTESTS.

Failure to do so may result in the loss of eligibility.

Student Name _____ Date _____ Student ID _____

Address _____ Telephone _____

School _____ Grade _____

1. PARENT/GUARDIAN CONSENT TO PLAY AND MEDICAL RELEASE

I hereby give my consent for the above named student to compete in sports at the above named high school and travel with a representative of the school on any trips. In case this student is injured, you are authorized to have him/her treated. (Ed. Code 35350)

SIGNATURE OF PARENT/GUARDIAN

Date

2. INSURANCE INFORMATION

California Ed. Code 32220 requires each member of an athletic team to have medical/accident insurance as set forth below. A Member of athletic team \cong includes band/orchestra members, cheerleaders, team managers, or any other student participating at an athletic event and while being transported to and from an athletic event. In accordance with Education Code Section 49472, the district does make available several insurance coverage plans Student Insurance Company. The insurance provides broad coverage for 24-Hour, At-School, Tackle Football, and Extended Dental. More information regarding Student Insurance is available on the district's website at <http://www.cv.k12.ca.us/parents/student-insurance>

INSURANCE REQUIREMENTS

Insurance protection for medical and hospital expenses resulting from bodily injuries in one of the following amounts:

- A group or individual medical plan with accident benefits of at least \$200 for each occurrence and major medical coverage of at least \$10,000, with no more than \$100 deductible and no less than 80% payable for each occurrence.
- Group or individual medical plans which are certified by the Insurance Commissioner to be equivalent to the required coverage of at least \$1,500.
- At least \$1,500 for all such medical and hospital expenses.

INSURANCE COVERAGE

____ Student Accident Insurance

____ 24-Hour Coverage

____ School Time Coverage

____ Tackle Football Coverage

____ Other Medical or Accident Insurance

NAME OF INSURANCE COMPANY

Policy # _____

I hereby certify that the above named student is covered by insurance that meets the requirement above, and agree to maintain this insurance during the time my student is participating in interscholastic sports.

SIGNATURE OF PARENT/GUARDIAN

Date

SPORTS PHYSICAL PHYSICIAN OFFICE FORM

Name: _____ Date of Birth: _____ Student ID: _____

Sports: _____ School: _____ Grade: _____ Male Female

EXPLAIN YES ANSWERS BELOW CIRCLE QUESTIONS YOU DO NOT UNDERSTAND

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Has a doctor ever denied or restricted your participation in sports? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have a medical condition (asthma/diabetes)? | <input type="checkbox"/> | <input type="checkbox"/> |

CARDIAC RISK:

- | | | |
|---|--------------------------|--------------------------|
| 1. Has any relative died of a heart condition suddenly before age 50? | <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|

- | | | |
|---|--------------------------|--------------------------|
| 2. Do you or your relatives have a history of: | | |
| a. Heart muscle disease such as hypertrophic cardiomyopathy? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Arrhythmia, irregular rhythm, pacemaker WPW (Wolf Parkinson White), Long QT syndrome or other cardiac problem? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Marfan Syndrome? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | | |
|---|--------------------------|--------------------------|
| 3. Does your heart race or skip beats during exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had chest pain during exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out or nearly passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have a history of high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. History of a heart murmur (other than innocent murmur) or other heart problem? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. History of unexplained dizziness with exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever had an ECG or Echocardiogram test for your heart? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. History of congenital heart disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. History of Carditis or Kawasaki disease? | <input type="checkbox"/> | <input type="checkbox"/> |

RESPIRATORY RISK:

- | | | |
|---|--------------------------|--------------------------|
| 1. History of cough, wheezing, or difficulty breathing during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever used an inhaler or taken asthma medication? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have a history of severe allergies to pollens, stinging insects, foods, or grasses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever been told by a doctor that you have asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. History of fractured ribs in the last 6 weeks? | <input type="checkbox"/> | <input type="checkbox"/> |

NEUROLOGICAL RISK:

- | | | |
|--|--------------------------|--------------------------|
| 1. History of head or neck injury, or concussion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever had amnesia or memory loss after a head injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or or falling? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. History of seizures? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. History of headaches with exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have a history of any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you wear glasses or contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. History of neck instability (i.e. Atlantoaxial Instability) | <input type="checkbox"/> | <input type="checkbox"/> |

INFECTION RISK:

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Do you have a history of recurrent or persistent rashes, pressure sores, herpes, or other skin infections? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been diagnosed or treated for a MRSA infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. History of Mono (EBV) in the last 4 weeks? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. History of recurrent unexplained fevers, or chronic coughing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you or any members of your household have a history of tuberculosis or positive PPD? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. History of Hepatitis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. History of HIV? | <input type="checkbox"/> | <input type="checkbox"/> |

ORTHOPEDIC RISK:

- | | | |
|--|--------------------------|--------------------------|
| 1. Have you ever broken any bones? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. History of neck or back injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. History of chronic back or neck pain? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. History of ankle, knee, hip injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. History of wrist, elbow, shoulder injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have any artificial limbs or prosthetic devices (false teeth)? | <input type="checkbox"/> | <input type="checkbox"/> |

OTHER PERTINENT QUESTIONS:

- | | | |
|--|--------------------------|--------------------------|
| 1. Are you taking any prescription or nonprescription (over the counter) medicines or pills? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you taking supplements or medications to gain or lose weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you taking medications or supplements to increase your strength or improve your sports performance? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you trying to gain or lose weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Were you born without or are you missing a kidney, eye, (if male testicle), (if female ovary) or other organ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. History of bleeding or clotting disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. History of severe muscle cramps or feeling severely ill when exercising in the heat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. History of surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. History of enlarged liver or spleen? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. History of sickle cell disease/trait? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. History of Hypoglycemia (low blood sugar)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Any medical changes since your last physical? | <input type="checkbox"/> | <input type="checkbox"/> |

FEMALES OLDER THAN 16 (OPTIONAL):

- | | | |
|---|--------------------------|--------------------------|
| 1. Have you had no periods? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you gone more than 90 days without a period in the last 6 months? | <input type="checkbox"/> | <input type="checkbox"/> |

EXPLAIN "YES" ANSWERS HERE: _____

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

Signature of athlete: _____ **Signature of parent/guardian:** _____ **Date:** _____

SPORTS PHYSICAL SCHOOL FORM

I grant permission to release the information below to School Personnel.

Signature of Parent/Guardian: _____

NAME: _____	Date of Birth: _____	Student ID: _____
Sports: _____	School: _____	Grade: _____
Emergency Contact: _____	Cell Phone: _____	Home Phone: _____
ALLERGIES: _____	MEDICATIONS: _____	

Date of Exam: _____ Height: _____ Weight: _____ BMI: _____ Pulse: _____ BP: _____/_____

HEARING: Passed Right/Left <25dbcls (all frequencies) Vision: R 20/____ L 20/____ Both 20/____ Corrected: Y N
 Failed _____ Not Done U/A: Normal _____

REQUIRED IMMUNIZATIONS: Measles, Mumps, Rubella, Hepatitis B, Polio, Tetanus, Pertussis, and Varicella/illness.

Up to date (See Attached Vaccine Documentation)

Not up to date, Vaccines Needed: _____

Date: _____ Baseline Concussion Assessment Completed (if not done, school will conduct the screening)

MEDICAL:	NORMAL	ABNORMAL FINDINGS
General Appearance		
Head eyes/ears/nose/throat		
Neck		
Respiratory		
Heart		
Pulses		
Abdomen		
Skin		
Neuro		
Lymph Nodes		
Genitourinary (males only)		

MUSCULOSKELETAL:	NORMAL	ABNORMAL FINDINGS
Back (including scoliosis screen)		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		

Assessment/Plan: _____

- Cleared for all sports without restrictions
- Not Cleared for: All sports Certain sports: _____
- Reason: _____
- Deferred requires further evaluation (See Recommendations Below):
- Cleared with restrictions (See Recommendations Below):

Recommendations: _____

Name of Physician (print): _____ Address: _____ Phone: _____

Signature of Physician: _____, M.D., D.O., or N.P. Date: _____

CVHS Athlete/Parent Participation Information for 2014 -2015

You are receiving this Athlete/Parent Participation information because your student has indicated an interest in participating in the interscholastic athletic program at Castro Valley High School. We hope that your student’s experiences will be positive as well as educational. Participation in athletics gives students the opportunity to learn leadership skills, foster self-confidence, self-discipline, organizational skills, decision-making skills, and goal setting. We believe a comprehensive athletic program is vital for the educational development of our students.

Castro Valley High School is committed to providing a complete athletic program and we can only do so through community donations and fundraising. Since there is **no** District funding for athletics, your support is critical to reach our goal of \$320,000 annually. In an effort to provide the wide variety of programs, we are including information about our 2014 - 2015 contribution campaign.

As a part of the contribution campaign effort, we are partnering with our Athletic Boosters and other organizations so that we can offer events and activities that will raise money for our program. From time to time, we will reach out to the community with information about opportunities to get involved and donate through phone calls, mailers, and flyers.

In order to provide our comprehensive athletic program, we have estimated the program costs per athlete per sport as follows:

<u>Fall Sports:</u>							
Spirit Squad	Football	Volleyball	Cross Country	Girls Golf	Girls Tennis		
\$300	\$350	\$275	\$225	\$325	\$225		
<u>Winter Sports:</u>							
Girls Basketball		Boys Basketball	Girls Soccer	Boys Soccer	Girls Wrestling	Boys Wrestling	
\$325		\$325	\$275	\$275	\$325	\$325	
<u>Spring Sports:</u>							
Swimming	Baseball	Boys Golf	Badminton	Boys Tennis	Boys Volleyball	Softball	Track
\$275	\$325	\$325	\$225	\$225	\$275	\$325	\$225

As we kick off our annual contribution campaign with the goal of providing your athlete with the opportunity to participate in interscholastic athletic programs at Castro Valley High School, please review and consider one of the options below to support our athletic program.

- Option A** Contribute amount in full (see sport contribution table above)
 _____ student for _____ sport

- Option B** I would like to make installments towards my contribution. Please attach 1st installment to form (Contact Finance Office to set up installment plan)
 _____ student for _____ sport

- Option C** I will fundraise to support the contribution campaign
 _____ student for _____ sport

- Additional Support** I would like to sponsor an athlete or a sport with the following tax-deductible contribution of:
 _____ amount for _____ sport

- Make checks payable to CVHS** (All contributions are tax-deductible)
- *Make sure you include the name of student & sport on your check*
 - *Contribution payment choices:*
 - Drop off or mail to the finance office at CVHS – 19400 Santa Maria Ave, CV, CA 94546
 - Contribute online on our website: www.castrovalleyhigh.org – Student Webstore - Athletics

Your signature below confirms that you have received this information. All information will remain confidential.

Parent Signature: _____ Print Name: _____

Parent Email address: _____ Student Name: _____ ID: _____

◊ Do not share my email with Athletic Boosters

Phone # _____ Cell # _____

Castro Valley High School Concussion Information Sheet

A concussion is a brain injury and all brain injuries are serious. They are caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, **all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly.** In other words, even a “ding” or a bump on the head can be serious. You can’t see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

Symptoms may include one or more of the following:	
<ul style="list-style-type: none">● Headaches● “Pressure in head”● Nausea or vomiting● Neck pain● Balance problems or dizziness● Blurred, double, or fuzzy vision● Sensitivity to light or noise● Feeling sluggish or slowed down● Feeling foggy or groggy● Drowsiness● Change in sleep patterns	<ul style="list-style-type: none">● Amnesia● “Don’t feel right”● Fatigue or low energy● Sadness● Nervousness or anxiety● Irritability● More emotional● Confusion● Concentration or memory problems (forgetting game plays)● Repeating the same question/comment

Signs observed by teammates, parents and coaches include:
<ul style="list-style-type: none">● Appears dazed● Vacant facial expression● Confused about assignment● Forgets plays● Is unsure of game, score, or opponent● Moves clumsily or displays incoordination● Answers questions slowly● Slurred speech● Shows behavior or personality changes● Can’t recall events prior to hit● Can’t recall events after hit● Seizures or convulsions● Any change in typical behavior or personality● Loses consciousness

Castro Valley High School

Concussion Information Sheet

What can happen if my child keeps on playing with a concussion or returns to soon?

Athletes with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one. This can lead to prolonged recovery, or even to severe brain swelling (second impact syndrome) with devastating and even fatal consequences. It is well known that adolescent or teenage athlete will often under report symptoms of injuries. And concussions are no different. As a result, education of administrators, coaches, parents and students is the key for student-athlete's safety.

If you think your child has suffered a concussion

Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear, without medical clearance. Close observation of the athlete should continue for several hours. Assembly bill 25 now is identical to the CIF bylaw 313 requiring implementation of long and well-established return to play concussion guidelines that have been recommended for several years (EC 49475).

“A student-athlete who is suspected of sustaining a concussion or head injury in a practice or game shall be removed from competition at that time and for the remainder of the day.”

and

“A student-athlete who has been removed may not return to play until the athlete is evaluated by a licensed health care provider trained in the evaluation and management of concussion and received written clearance to return to play from that health care provider”.

You should also inform your child's coach if you think that your child may have a concussion Remember its better to miss one game than miss the whole season. And when in doubt, the athlete sits out.

For current and up-to-date information on concussions you can go to:

<http://www.cdc.gov/ConcussionInYouthSports/>

Student-athlete Name Printed

Student-athlete Signature

ID

Date

Parent or Legal Guardian Printed

Parent or Legal Guardian Signature

Date

**Castro Valley High School Athletics
2014 - 2015
Athletic Transfer Screening Form**

Name: _____ ID: _____
 Address: _____ Phone: _____
 Date of Birth: _____

School attended LAST school year _____

Have you attended any other high schools? If yes, list school name and dates attended:

Sports you plan to play this school year:

Fall	Winter	Spring
<input type="checkbox"/> Cross Country <input type="checkbox"/> Football <input type="checkbox"/> Girls Golf <input type="checkbox"/> Girls Tennis <input type="checkbox"/> Girls Volleyball <input type="checkbox"/> Spirit Squad	<input type="checkbox"/> Boys Basketball <input type="checkbox"/> Boys Soccer <input type="checkbox"/> Girls Basketball <input type="checkbox"/> Girls Soccer <input type="checkbox"/> Boys Wrestling <input type="checkbox"/> Girls Wrestling	<input type="checkbox"/> Badminton <input type="checkbox"/> Baseball <input type="checkbox"/> Boys Golf <input type="checkbox"/> Boys Tennis <input type="checkbox"/> Boys Volleyball <input type="checkbox"/> Softball <input type="checkbox"/> Swimming/Diving <input type="checkbox"/> Track

TRANSFER STUDENTS – ATHLETIC ELIGIBILITY

Transferring from one school to another may affect your athletic eligibility under North Coast Section and/or California Interscholastic Federation rules. It is **YOUR RESPONSIBILITY** to see your new Athletic Director for a copy of the rules. The period of ineligibility is one calendar year. Students who intend to participate in athletics **MUST SEE THEIR ATHLETIC DIRECTOR IMMEDIATELY IF:**

1. They change their residence while attending current school;
2. They plan to transfer to another school without changing their residence;
3. They are or have moved from one parent/guardian to another parent/guardian.

Failure on the part of an athlete to report his/her change of residence to the principal of the school he/she is attending may result in:

1. Forfeiture of all contests won by the team on which the ineligible student played;
2. Athletic ineligibility status for the athlete for at least one calendar year in any California senior high school even though he/she is allowed to remain in that school.

I understand that as my student changes residence, I am responsible for immediately informing the principal of the school that the student is currently attending.

Signature of Parent/Guardian

Date

Relationship to Student



Support Castro Valley High School Athletics!

No Cost to You! How It Works. By registering for eScrip, local merchants contribute 1% to 3% of your purchases directly to support our school. It costs you nothing, and does not change the price you pay. It's the merchant's way of supporting our community!

Group ID: 137636655

Castro Valley Athletic Boosters

Name _____
Address: _____
City: _____ Zip _____
Phone: _____ Email _____

This is my first registration
 Adding this Organization. I have previously registered cards for the eScrip program and would like to add **CVHS Athletic Boosters** as an additional beneficiary
 SWITCH my registration from _____
(other organization)

I accept the eScrip program and authorize the CVHS Athletic Boosters to receive donations and update/renew my account information unless otherwise notified

Signature _____ Date _____


Local Supermarket Cards

Register and/or request your shopping card from the following merchant:

SAFeway CLUB CARD # _____

****CLUB CARD # IS REQUIRED. (We can't use a phone # to register) Call Safeway to get your Club Card # or to get a FREE card 1 (877) 723 - 3929**

(Name and Address Required Above)

LUCKY Yes, Send a S.H.A.R.E.S. card 

Credit Card Registration

Purchases on your VISA, MasterCard, Amex, ATM and Discover Cards also generate contributions to our school. Or if you prefer to register your credit cards online, go to the secure eScrip site at www.eScrip.com.

Be sure to include our Group ID# 137636655 CVHS Athletic Boosters

	Expiration Date
ATM/DEBIT CARD # _____	_____/____/_____
VISA # _____	_____/____/_____
MasterCard # _____	_____/____/_____
American Express # _____	_____/____/_____
Discover # _____	_____/____/_____

In as little as 12 months your contributions will be...

	eScrip Merchants contribute...		100 families
If you spend... (per month)	\$250	\$2.50	\$3,000
	\$400	\$5.00	\$6,000
	\$550	\$10.50	\$12,600
	\$650	\$14.00	\$16,800

These numbers are for illustrative purposes only. Merchant contribution percentages vary by merchant, please visit www.escrip.com for your eScrip merchant contributions in your area.