# THOMPSON SCHOOL DISTRICT

## CHECKLIST FOR ATHLETIC PARTICIPATION

**Part A - PARENT PERMIT FOR ATHLETIC PARTICIPATION AND INSURANCE COVERAGE**

Read and complete with parent or guardian. Release must be signed by parent and returned to the school office.

**Part B – SIGNATURE PAGE**

Acknowledgement for Code of Conduct, Training Rules and Standards for Communication

- Health Information
- Medicaid Information
- Student Eligibility Information CHSAA form

**Part C - MEDICAL**

- **Part I Medical History** Complete with your parents and obtain signatures prior to physical examination.

- **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.

*Both parts to be returned to the school office.*

**Part D - ATHLETIC INJURY/EMERGENCY INFORMATION**

Thompson School District

OCR

- Athletic Injury Emergency Information

*Both forms must be signed and completed at the beginning of each season of participation.*

## ATHLETIC FEE:

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)

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.
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

**Name:** ____________________________  **Sex:** ____  **Age:** _____  **Date of Birth:** ________________

**Date ____________________**  **Personal Physician ___________________________________**

**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 you ever had chest pain during or after exercise?  
  - Yes [ ]  
  - No [ ]

- Do you tire more quickly than your friends during exercise?  
  - 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 you ever had chest pain during or after exercise?  
  - Yes [ ]  
  - No [ ]

- Do you tire more quickly than your friends during exercise?  
  - Yes [ ]  
  - No [ ]

- 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 your 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?  
  - Yes [ ]  
  - No [ ]

- 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 injuries of any bones or joints?  
  - Yes [ ]  
  - No [ ]

- 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: ________________________________________________

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<tr>
<th><strong>Physical Examination</strong></th>
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<td><strong>Height ____________</strong></td>
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<td><strong>Cardiopulmonary</strong></td>
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<td><strong>Ankle</strong></td>
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<td><strong>Other</strong></td>
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**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 _____________________________________________________________**

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

**DATE: ________________________________________**
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.
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:

Allergy                                           Medications/Dosage Being Taken
_________________________________________________________

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 ______________

_________________________________________________________        Date ______________

Parent or Guardian