## THOMPSON SCHOOL DISTRICT
### CHECKLIST FOR ATHLETIC PARTICIPATION

<table>
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<tr>
<th>Check as completed</th>
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<th>Revised 5/5/15</th>
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<tbody>
<tr>
<td></td>
<td><strong>Part A - PARENT PERMIT FOR ATHLETIC PARTICIPATION AND INSURANCE COVERAGE</strong></td>
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<td>Read and complete with parent or guardian. Release must be signed by parent and returned to the school office.</td>
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<td><strong>Part B – SIGNATURE PAGE</strong></td>
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<td>Acknowledgement for Code of Conduct, Training Rules and Standards for Communication Anti-Hazing Policy CHSAA form</td>
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<td><strong>Part C - ATHLETIC INJURY/EMERGENCY INFORMATION</strong></td>
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<td>Thompson School District</td>
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<td>Form must be signed and completed at the beginning of each season of participation.</td>
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<td><strong>PART D - MEDICAL</strong></td>
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<td>Physician Clearance</td>
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<td>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. To be valid, a physical must have been given within the last 365 calendar days.</td>
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<td><strong>ATHLETIC FEE:</strong></td>
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<td>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). High school family maximum of $325.00 per family per school year for enrolled students; family maximum for non-enrolled students is $460.00. $50 middle school enrolled/$70 middle school non-enrolled or $20 intramural enrolled/$30 intramural non-enrolled. Middle school family maximum of $125.00 per family per school year for enrolled students; family maximum for non-enrolled students is $175.00. <strong>Athletic fee must be paid before</strong> the issuance of clearance to participate. 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)</td>
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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.)
**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.** Despite the rules and regulations geared toward safety and protecting athletes in all sports, along with the extensive amount of equipment that some athletes must wear to participate in their sport, the very nature and physicality of contact and non contact sports can easily lead to injury and neither equipment nor training will eliminate the risk of injury. 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: ____________________

Anti-Hazing Policy

The Colorado High School Activities Association prohibits bullying, hazing, intimidation or threats. Hazing includes but is not limited to humiliation tactics, forced social isolation, verbal or emotional abuse, forces or excessive consumption of food or liquids, or any activity that requires a student to engage in illegal activity. I understand that hazing of any type is not permitted in a CHSAA sanctioned activity.

I will not engage in any of the prohibited conduct. I further understand that it is my responsibility to immediately report any acts of hazing that I become aware of to a sponsor, teacher, counselor, school support staff, coach or administrator in my school.

By signing this acknowledgement, I affirm my responsibility to prevent and report hazing. I also understand that any violation of this could result in school or team consequences that could include dismissal from the activity of further disciplinary consequences and/or referral to law enforcement.

Date: ___________ Student Athlete Signature: ________________________________
ATHLETIC INJURY EMERGENCY INFORMATION

Athlete ________________________________________________________________

Birthdate_______ Class _______ Height _______ Weight ________________

Parent/Guardian ___________________________________________ Home Phone___________

Address ___________________________________________ Cell Phone _______________

Other Emergency Contact _____________________________ Home Phone _______________

Family Physician _______________________________ Bus. 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 (circle 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 ____________
PHYSICIAN CLEARANCE

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

RECOMMENDATIONS: ____________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

NAME OF PHYSICIAN/ PA/ NURSE PRACTITIONER/ CERTIFIED-REGISTERED CHIROPRACTOR:
_____________________________________________________________________________
ADDRESS _____________________________________________________________
PHONE __________________
SIGNATURE OF MD/DO,PA/NA,DC-SPC# ____________________________________________
DATE: ________________________________