Student Last Name	Student First Name	Grade	Student ID #	Sport(s) planned to play 11/12

Athletic Packet Signature Page

We acknowledge that we have read, understand and agree to the following information and documentation:

☐ I have read and agree to abide by all regulations in the Extra/Co-curricular Handbook and any rules set forth by individual coaches. If I have any questions or need any clarification on any part of the handbook it is my responsibility to request this information from the Athletic Director. The sport(s) or activity(ies), by their very nature poses some inherent risk of a participant being seriously injured. These injuries could, but are not limited to the following: Sprains/strains/fractures, Disfigurement, Cuts/abrasions, Head injuries, Unconsciousness, Loss of eyesight, Paralysis, Death.

☐ I understand that participation in this sport/activity is **voluntary and is not required by the school district.** The undersigned has read and hereby agrees to hold the Pleasanton Unified School District, its employees, agents, volunteers and/or sponsors and any other person, firm or corporation charged or chargeable with responsibility or liability, free and harmless from any and all claims, demands, damages, costs, expenses, loss of services, action and causes of action resulting from the use of the facilities, equipment and participation by the student in the above named sport(s).

☐ In the event of an illness or injury, I do hereby consent to medical/hospital treatments that are determined necessary in the best judgment of the attending physicians or dentists.

☐ Medical exams are required for all high school playing field participants (including cheerleaders). An annual physical examination stating that the student is physically fit to participate in athletics is required before a student may try out, practice or participate in interscholastic athletic competition. (Attach physical form). **Date of Physical:**

☐ I realize that by participation in any school activity, I am a representative of my school and community; therefore, I understand the above standards and expectations are my responsibility. I will embrace Pleasanton's Community of Character expectations: Responsibility, Compassion, Self-Discipline, Honesty, Respect, and Integrity. I have read the Student Handbook and will abide by its regulations. I also have read and agree to this Code of Conduct and will accept the consequences should I choose not to follow these standards. **Student's Initials:____________**

☐ As parent or Guardian of a PUSD student, I have read the Code of Conduct, and I am familiar with the Student Handbook for Interscholastic Athletics and Co-Curricular Activities, and I will support my student in reaching these standards.
Parent/Guardian's Initials:_____________

☐ I have read the Athletic Eligibility Screening information and understand the rules regarding address changes, school transfers and eligibility requirements. I will report directly to the principal immediately if any of the following happens during my participation in a sport/activity: 1—Change of residence while attending current school, 2—Plan to transfer to another school without changing residence, 3—Moved from one parent/guardian to another parent/guardian. I understand that it is my responsibility to report changes of residence to the principal.

☐ I have read and Agree to the Non-Use Steroid Agreement.

☐ I have read and agree to NCS Ejection policy

☐ I have read the Athletic Insurance Information/Waiver and can attest to one of the following:

- ☐ I have health or accident insurance for my daughter or son, which meets the requirements of California law and elect not to purchase student insurance.

Family Physician's Name: Do you have medical insurance? ☐ Yes ☐ No
Plan Name and Policy/Group #

OR

- ☐ I have sent a check for accident insurance as indicated below in order to meet the requirements of The California law [check the appropriate response(s)]
    - ☐ Tackle Football Insurance (covers tackle football only)
    - ☐ School Time Insurance (covers sports other than football)
    - ☐ Full Time Insurance (covers sports other than football)

Student Signature:____ Date:_______________________

Parent Signature:____ Date:_______________________

COMPLETE THIS FORM *PRIOR TO GOING TO THE DOCTOR*

PROVIDE FORM TO DOCTOR COMPLETING PHYSICAL *DO NOT RETURN TO THE SCHOOL.*

SPORTS PHYSICAL

Name: ____________________________ Date of Birth: ________ Student ID: ___________

Sport(s): __________ School: Amador Valley High School Grade: _____ Gender: ______

Fill Boxes with a Y or N. EXPLAIN YES ANSWERS BELOW. CIRCLE QUESTIONS YOU DO NOT UNDERSTAND

Question	Y/N
1. Has a doctor ever denied or restricted your participation in sports?	
2. Do you have a medical condition (athsma/diabetes?)	
Cardiac Risk:	
1. Has any relative died of a heart condition suddenly before age 50?	
2. Do you or your relatives have a history of:	
a. Heart muscle disease such as hypertrophic cardiomyopathy?	
b. Arrhythmia, irregular rhythm, pacemaker, WPW (Wolf Parkinson White), Long QT syndrome or other cardiac problem?	
c. Marfan Syndrome	
3. Does your heart race or skip beats during exercise?	
4. Have you ever had chest pain during exercise?	
5. Have you ever passed out or nearly passed out during or after exercise?	
6. Do you have a history of high blood pressure?	
7. History of a heart murmur (other than innocent murmur) or other heart problem?	
8. History of unexplained dizziness with exercise?	
9. Have you ever had an ECG or Echocardiogram test for your heart?	
10. History of congenital heart disease?	
11. History of Carditis or Kawasaki disease?	
Respiratory Risk:	
1. History of cough, wheezing or difficulty breathing during or after exercise?	
2. Have you ever used an inhaler or taken asthma medication?	
3. Do you have a history of severe allergies to pollens, stinging insects, foods, or grasses?	
4. Have you ever been told by a doctor that you have asthma?	
5. History of fractured ribs in the last 6 weeks?	
Neurological Risk:	
1. History of head or neck injury, or concussion?	
2. Have you ever had amnesia or memory loss after a head injury?	
3. Have you ever had numbness, tingling or weakness in your arms or legs after being hit or falling?	
4. History of seizures?	
5. History of headaches with exercise?	
6. Do you have a history of any problems with your eyes or vision?	
7. Do you wear glasses or contact lenses	
8. History of neck instability (i.e. atlantoaxial instability)	

Question	Y/N
Infection Risk	
1. Do you have a history of recurrent or persistent rashes, pressure sores, herpes or other skin infections?	
2. Have you ever been diagnosed or treated for a MRSA infection?	
3. History of Mono (EBV) in the last 4 weeks?	
4. History of recurrent unexplained fevers, or chronic coughing?	
5. Do you or any members of your household have a history of tuberculosis or positive PPD?	
6. History of Hepatitis?	
7. History of HIV?	
Orthopedic Risk	
1. Have you ever broken any bones?	
2. History of neck or back injury?	
3. History of chronic back or neck pain?	
4. History of ankle, knee, hip injury?	
5. History of wrist, elbow, shoulder injury?	
6. Do you have any artificial limbs or prosthetic devices (false teeth)?	
Other Pertinent Questions	
1. Are you taking any prescription or nonprescription (over the counter) medicines or pills?	
2. Are you taking supplements or medications to lose weight?	
3. Are you taking medications or supplements to increase your strength or improve your sports performance?	
4. Are you trying to gain or lose weight?	
5. Were you born with or are you missing a kidney, eye, (if make testicle), (if female ovary) or other organ?	
6. History of bleeding or clotting disorder?	
7. History of severe muscle cramps or feeling severely ill when exercising in the heat?	
8. History of surgery?	
9. History of enlarged liver or spleen?	
10. History of sickle cell disease/trait?	
11. History of Hypoglycemia (low blood sugar)?	
FEMALES OLDER THAN 16 (OPTIONAL)	
1. Have you had no menstrual cycles?	
2. Have you gone more than 90 days without a period in the last 6 months?	

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________

RETURN THIS FORM TO THE SCHOOL

ATHLETE PHYSICAL EXAMINATION FORM

PHYSICIAN'S FINDINGS/ASSESSMENT

Fill out this section before going to the doctor.

Name:_______________ **Date of Birth:** ___________ **Student ID #:** ___________
Sport(s): _______________ **School: Amador Valley High School** **Grade:** ________
Emergency Contact: ___________ **Cell Phone:** _____________ **Home Phone:**_____________
Allergies: _______________ **Medications:**_______________

Date of Exam:_______________ Height:________ Weight:________ Pulse:_______ BP:____/____

Hearing: ☐ Passed Right/Left ≤25dcbls (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, and tetanus.

☐Received Varicella Vaccine/or Varicella illness after 1 yr. of age Date of Last Teatnus________

☐Up to date (see attached Vaccine Documentation) ☐Not up to Date. Vaccines needed:_______________

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

MUSCULOSKELETAL

Back(+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. or D.O. Date_______________

I grant permission to release the information above to School Personnel

Parent/Guardian Signature:_______________

2 COPIES NEEDED

Athletic Training Contract/Emergency Information

Dear Parents,

Tri Valley Orthopedic Specialists provides Athletic Training services for Amador Valley High School if an athlete is injured at practice or during a school sponsored competition. These services include: 1) On-field injury management, 2) Evaluation of injury, and 3) Post-injury treatment plan in conjunction with our rehabilitation department (Physical Therapy). The purpose of this letter is to inform you of our services and to **request your authorization to treat your son/daughter in our sports medicine clinic or athletic training room, in the event an injury should occur**. Following the evaluation of your son/daughter's injury, we will notify you *and* your son/daughter's coach regarding their status and an appropriate treatment plan. ***WE ARE UNABLE TO TREAT YOUR SON or DAUGHTER WITHOUT THIS COMPLETED AND SIGNED AUTHORIZATION.***

Please sign this letter, complete the emergency information and return of it to Student Activities at Amador Valley High School. **If you have any further questions relating to this program, please contact Diana Hasenpflug, MS, ATC, at 925.895.9244.** Thank you for your assistance in caring for our athletes.

Diana Hasenpflug, MS, ATC
Athletic Trainer, Amador Valley High School

Student Name: ______________________________ Student ID: ______________

RELEASE OF LIABILITY

I hereby grant permission to the athletic training personnel to assess the injury and make appropriate recommendations upon assessment deemed reasonably necessary to the health and well being of the athlete named. I understand this assessment is not intended to replace a physician's diagnosis/care and should not be viewed as substitute. In the event that the athletic training personnel determine that further medical attention is deemed necessary, the athlete will be referred to a physician immediately. I understand that in the event that no progress has been made within 2 weeks of the initial evaluation, the athletic training personnel reserves the right to defer treatment at that time, and the appropriate referral will be made. I further release Tri-Valley Orthopedic Specialists and employees from any liability for damage and injury to the named athlete and hereby accept the full responsibility for any damages or injury sustained as a result of participation in sports and extracurricular activities. I attest that the student information is correct to the best of my knowledge. I have reviewed all information and hereby give consent for the assessment of injury to the named student athlete.

______________________________ ______________
Signature of Parent/Guardian Date

______________________________ ______________
Signature of Student Athlete Date

Emergency Contact Information

Last Name: ______________ First Name: ______________ M.I.: ____
Gender: ____________ Age: __________ Birthdate: ______________
Home Address: ______________________________
City: ______________ State: ______________ Zip: ______________
Home Phone: ______________ Alternate Phone: ______________
Parent/Guardian Name(s): ______________________________
Parent/Guardian Address: ______________________________
Parent/Guardian: Home Phone: ________ Cell Phone: ________ Work Phone: ________

If neither parent can be reached by phone in case of emergencies, please call the following contact:

Name: __________ Relation: __________ Home Phone: ________ Work Phone: ________
Physician's Name: ______________ Physician's Phone: ______________
Dentist's Name: ______________ Dentist's Phone: ______________
Health Plan/Insurance Medical Plan # ____________ Plan Name ______________
Additional Instructions: (hospital preference, medications, etc.)______________________

Medical History: (circle yes or no for each question)

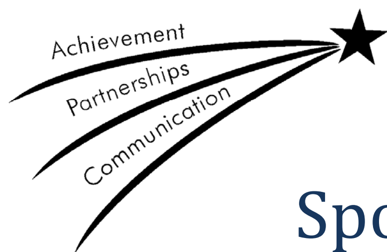
1. Has your Child ever been hospitalized? Yes / No
2. Has Your child ever had chest pain during or after exercise or had high blood pressure? Yes / No
3. Has your child ever had a seizure? Yes / No
4. Does your child have trouble breathing during/after Activities? Yes / No
5. Does your child have any allergies? Yes / No
6. Has your child ever had surgery? Yes / No
7. Has your child ever been told they have a heart murmur? Yes / No
8. Has anyone in your family died of heart problems or sudden death before age 50? Yes / No
9. Has your child ever had any other medical problems? Yes / No
10. Is your child presently taking any medications? Yes / No

If you answered YES to any of the above, please explain and/or list any medications or allergies:______________________

____

Pleasanton Unified School District

Pupil Services



Sports Safety Awareness

Concussion:

Concussion is a brain injury. To increase concussion awareness, the Center for Disease Control and Prevention (CDC) has developed the attached information sheet; please review it with your child. If you have any questions, please consult your child's coach or health care provider.

Heart Screening:

Sudden cardiac deaths have been reported among competitive athletes. It occurs as a result of exertion-related genetic cardiac condition called Hypertrophic Cardiomyopathy (HCM). Athletes may show no symptoms. Heart screening by a qualified health care provider may identify this underlying heart condition. If you have a family history of sudden cardiac arrest or you have any concerns, please consult your child's health care provider. If you would like to self refer, ask your child's health care provider for any recommendations.

I have read the Sports Safety Awareness information with my child.

_______________________________ _____________________

Parent Date

_______________________________ _____________________

Student Date

4661 Bernal Avenue, Pleasanton, California 94566 • 925\426-4290

FAX: 925\426-7146 website: www.pleasanton.k12.ca.us