

Student Last Name	Student First Name	Grade	Student ID #	Sport(s) planned to play 10/11

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: _____
Plan Name and Policy/Group # _____

Do you have medical insurance? Yes No

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

<p>1. Has a doctor ever denied or restricted your participation in sports?</p> <p>2. Do you have a medical condition (athsma/diabetes?)</p> <p>Cardiac Risk:</p> <p>1. Has any relative died of a heart condition suddenly before age 50?</p> <p>2. Do you or your relatives have a history of:</p> <p style="padding-left: 20px;">a. Heart muscle disease such as hypertrophic cardiomyopathy?</p> <p style="padding-left: 20px;">b. Arrhythmia, irregular rhythm, pacemaker, WPW (Wolf Parkinson White), Long QT syndrome or other cardiac problem?</p> <p style="padding-left: 20px;">c. Marfan Syndrome</p> <p>3. Does your heart race or skip beats during exercise?</p> <p>4. Have you ever had chest pain during exercise?</p> <p>5. Have you ever passed out or nearly passed out during or after exercise?</p> <p>6. Do you have a history of high blood pressure?</p> <p>7. History of a heart murmur (other than innocent murmur) or other heart problem?</p> <p>8. History of unexplained dizziness with exercise?</p> <p>9. Have you ever had an ECG or Echocardiogram test for your heart?</p> <p>10. History of congenital heart disease?</p> <p>11. History of Carditis or Kawasaki disease?</p> <p>Respiratory Risk:</p> <p>1. History of cough, wheezing or difficulty breathing during or after exercise?</p> <p>2. Have you ever used an inhaler or taken asthma medication?</p> <p>3. Do you have a history of severe allergies to pollens, stinging insects, foods, or grasses?</p> <p>4. Have you ever been told by a doctor that you have asthma?</p> <p>5. History of fractured ribs in the last 6 weeks?</p> <p>Neurological Risk:</p> <p>1. History of head or neck injury, or concussion?</p> <p>2. Have you ever had amnesia or memory loss after a head injury?</p> <p>3. Have you ever had numbness, tingling or weakness in your arms or legs after being hit or falling?</p> <p>4. History of seizures?</p> <p>5. History of headaches with exercise?</p> <p>6. Do you have a history of any problems with your eyes or vision?</p> <p>7. Do you wear glasses or contact lenses</p> <p>8. History of neck instability (i.e. atlantoaxial instability)</p>	<p>Infection Risk</p> <p>1. Do you have a history of recurrent or persistent rashes, pressure sores, herpes or other skin infections?</p> <p>2. Have you ever been diagnosed or treated for a MRSA infection?</p> <p>3. History of Mono (EBV) in the last 4 weeks?</p> <p>4. History of recurrent unexplained fevers, or chronic coughing?</p> <p>5. Do you or any members of your household have a history of tuberculosis or positive PPD?</p> <p>6. History of Hepatitis?</p> <p>7. History of HIV?</p> <p>Orthopedic Risk</p> <p>1. Have you ever broken any bones?</p> <p>2. History of neck or back injury?</p> <p>3. History of chronic back or neck pain?</p> <p>4. History of ankle, knee, hip injury?</p> <p>5. History of wrist, elbow, shoulder injury?</p> <p>6. Do you have any artificial limbs or prosthetic devices (false teeth)?</p> <p>Other Pertinent Questions</p> <p>1. Are you taking any prescription or nonprescription (over the counter) medicines or pills?</p> <p>2. Are you taking supplements or medications to lose weight?</p> <p>3. Are you taking medications or supplements to increase your strength or improve your sports performance?</p> <p>4. Are you trying to gain or lose weight?</p> <p>5. Were you born with or are you missing a kidney, eye, (if male testicle), (if female ovary) or other organ?</p> <p>6. History of bleeding or clotting disorder?</p> <p>7. History of severe muscle cramps or feeling severely ill when exercising in the heat?</p> <p>8. History of surgery?</p> <p>9. History of enlarged liver or spleen?</p> <p>10. History of sickle cell disease/trait?</p> <p>11. History of Hypoglycemia (low blood sugar)?</p> <p>FEMALES OLDER THAN 16 (OPTIONAL)</p> <p>1. Have you had no menstrual cycles?</p> <p>2. Have you gone more than 90 days without a period in the last 6 months?</p> <p>EXPLAIN YES ANSWERS HERE:</p>
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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 ≤ 25 dcbls (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: _____

Athletic Training Contract/Emergency Information 2 COPIES NEEDED

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: _____

Additional Instructions: (hospital preference, etc.) _____

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

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

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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: _____

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