

# CARROLL I.S.D. ATHLETIC PARTICIPATION RELEASE

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Sex:  M  F Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

School: CSHS CHS CMS DMS Grade (Entering): 7<sup>th</sup> 8<sup>th</sup> 9<sup>th</sup> 10<sup>th</sup> 11<sup>th</sup> 12<sup>th</sup> School Year: \_\_\_\_ - \_\_\_\_

Please check all sports/activities in which student is planning to participate:

Football  Volleyball  Basketball  Soccer  Baseball  Softball  Cross Country  
 Track  Golf  Tennis  Wrestling  Swimming  Other \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Telephone: \_\_\_\_\_

Mother/Guardian: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Employer: \_\_\_\_\_

Father/Guardian: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Employer: \_\_\_\_\_

Alternate Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy and/or Group # \_\_\_\_\_

## Parent/Guardian Permit, UIL Rules & Insurance Notice

I hereby give my consent for the above student to compete in University Interscholastic League approved sport, and travel with the coach or other representative of the school on any trips.

It is understood that even though protective equipment is worn by the athlete whenever needed, the possibility of an accident still remains. Neither the University Interscholastic League nor CISD assumes any responsibility in case an accident occurs.

The undersigned agrees to be responsible for the safe return of all athletic equipment issued by the school to the above named student.

Your signature below gives authorization that is necessary for the school district, its athletic trainers, coaches, associated physician and student insurance personnel to share information concerning medical diagnosis and treatment for your student.

I have read and understand the following University Interscholastic League rules and agree that my son/daughter will abide by all of the University Interscholastic League rules. *According to UIL standards, students are eligible to represent their school in interscholastic activities if they: (1) are not 19 years of age or older on or before Sept. 1 of the current scholastic year (See 504 handicapped exception.); (2) have not graduated from high school; (3) are enrolled by the 6th class day of the current school year or have been in attendance for 15 calendar days immediately preceding a varsity contest; (4) are full-time day students in a participant high school; (5) initially enrolled in the 9th grade not more than 4 calendar years ago; (6) are meeting academic standards required by state law; (7) live with their parents inside the school district attendance zone their 1st year of attendance (varsity eligibility only), [When the parents do not reside inside the district attendance zone the student could be eligible if: the student has been in continuous attendance for at least one calendar year and has not enrolled at another school, no inducement is given to the student to attend the school (ex. student or parent must pay their room & board when they do not live with a relative or transportation costs when driving back into the district), & it is not a violation of local school or TEA policies for the student to continue attending the school, students placed by the Texas Youth Commission are covered under Custodial Residence]; (8) have observed all provisions of the Awards Rule; (9) have not represented a college in a contest; (10) have not been recruited (Does not apply to college recruiting as permitted by rule.); (11) have not violated any provision of the summer camp rule [Incoming 10-12 grade students shall not attend a baseball, basketball, football, soccer, or volleyball camp in which a 7-12 grade coach from their school district attendance zone, works with, instructs, transports or registers that student in the camp. Students who will be in grades 7,8, & 9 may attend one baseball, one basketball, one football, one soccer, one softball & one volleyball camp in which a coach from their school district attendance zone is employed, for no more than 6 consecutive days each summer in each type of sports camp. Baseball, Basketball, Football, Soccer, Softball, & Volleyball camps where school personnel work with their own students may be held in May, after the last day of school, June, July & August prior to the 2nd Monday in August. If such camps are sponsored by school district personnel, they must be held within the boundaries of the school district & the superintendent, or his designee, shall approve the schedule of fees]; (12) have observed all provisions of the Athletic Amateur Rule [Students may not accept money or other valuable consideration, items which are wearable, salable, or usable, for participating in any athletic sport during any part of the year. Athletes shall not allow their names to be used for the promotion of any product, plan or service. Students who inadvertently violate the amateur rule by accepting valuable consideration may regain athletic eligibility by returning the valuable consideration. If individuals return the valuable consideration within 30 days after they are informed of the rule violation, they regain their athletic eligibility when they return it. If they fail to return it within 30 days, they remain ineligible for one year from when they accepted it. During the period of time from when the student receives valuable consideration until they return it, they are ineligible for all varsity athletic competition. Minimum penalty for participating in a contest while ineligible is forfeiture of the contest]; (13) did not change schools for athletic purposes.*

I understand that the Carroll Independent School District will provide me the option to purchase insurance coverage for students participating in interscholastic athletics. If I choose to purchase this insurance, it is my responsibility to follow all the procedures set forth in the policy. I understand that it is my responsibility to file claims with my insurance carrier(s), including the school provided insurance option, and to pay for any costs that may not be covered by insurance. I also understand that CISD will NOT be responsible for any costs incurred due to an injury that may occur during athletic participation. I hereby agree to pay for all costs of any injuries that may occur during the athletic participation of said student.

I have read and understand this form in its entirety and attest to the accuracy of the information contained herein. I agree to notify proper school officials if there is a change of information during the school year. If, between this date and the beginning of athletic competition, any illness or injury should occur that may limit this student's participation, I agree to notify the athletic trainers, coaches, or other school officials of such illness or injury.

**To the parent:** Please circle any activity this student is allowed to participate in:

baseball, basketball, cross country, football, golf, soccer, softball, swimming, tennis, track & field, volleyball, wrestling, other \_\_\_\_\_

If, in the judgment of any representative of CISD, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse, or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student.

**No student will be permitted to participate in any practice, athletic period, or contest prior to this document and a current physical examination being on file with the athletic department at the student's school.**

**I have read, understand, and agree to all of the rules and provisions set forth.**

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Student Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Medical History Form**

Explain "Yes" answers, including dates, in the space on the bottom right.

Circle questions you don't know the answers to.

- |  | <b>YES</b>               | <b>NO</b>                |
|--|--------------------------|--------------------------|
| 1. Have you had a medical illness or injury since your last check up or sports physical?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you been hospitalized overnight in the past year?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had surgery?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have any allergies (for example to medicine, food, pollen, stinging insects, etc.)?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out during or after exercise?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been dizzy during or after exercise?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had chest pain during or after exercise?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you get tired more quickly than your friends do during exercise?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had racing of your heart or skipped heartbeats?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had high blood pressure or high cholesterol?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been told you have a heart murmur?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Has any family member or relative died of heart problems or of sudden unexpected death before age 50?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Has any family member been diagnosed with enlarged heart, hypertrophic cardiomyopathy, long QT syndrome, Marfan's syndrome, or abnormal heart rhythm?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had a severe viral infection (for ex. myocarditis or mononucleosis) within the last month?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Has a physician ever denied or restricted your participation in sports for any heart problems?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have any current skin problems (for example itching, rashes, acne, warts, fungus, or blisters)?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had a head injury or concussion?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been knocked out, become unconscious or lost your memory? (Explain severity of each below.).....   | <input type="checkbox"/> | <input type="checkbox"/> |
| How many times? _____ Date of most recent? _____   |                          |                          |
| Have you ever had a seizure?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have frequent or severe headaches?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had numbness or tingling in your arms, hands, legs, or feet?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a stinger, burner, or pinched nerve?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever become ill from exercising in the heat?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever gotten unexpectedly short of breath with exercise? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you cough, wheeze, or have trouble breathing during or after activity?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have asthma?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have seasonal allergies that require medical treatment?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you had any problems with your eyes or vision?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you wear glasses or contacts?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Are you missing any paired organs?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you ever had a sprain, strain, or swelling after injury?...   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you broken or fractured any bones or dislocated any joints?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, check appropriate box and explain below:   |                          |                          |
| <input type="checkbox"/> Head <input type="checkbox"/> Chest <input type="checkbox"/> Elbow/Forearm <input type="checkbox"/> Hip <input type="checkbox"/> Shin/Calf  |                          |                          |
| <input type="checkbox"/> Neck <input type="checkbox"/> Shoulder <input type="checkbox"/> Wrist <input type="checkbox"/> Thigh <input type="checkbox"/> Ankle   |                          |                          |
| <input type="checkbox"/> Back <input type="checkbox"/> Upper Arm <input type="checkbox"/> Hand/Finger <input type="checkbox"/> Knee <input type="checkbox"/> Foot  |                          |                          |
| 14. Do you want to weigh more or less than you do now?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you lose weight regularly to meet weight requirements for your sport? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you feel stressed out?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Record the dates of your most recent immunizations (shots) for:  |                          |                          |
| Tetanus _____ Measles _____  |                          |                          |
| Hepatitis B _____ Chickenpox _____   |                          |                          |
| 17. Are you currently under a doctor's care?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. When was your first menstrual period? _____  |                          |                          |
| When was your most recent period? _____  |                          |                          |
| How much time do you usually have from the start of one period to the start of another? _____  |                          |                          |
| How many periods have you had in the last year? _____  |                          |                          |
| What was the longest time between periods in the last year? _____  |                          |                          |

**Physical Form**

CISD policy requires the completion of an annual physical exam.

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Pulse: \_\_\_\_\_  
 BP: \_\_\_\_\_/\_\_\_\_\_ (\_\_\_\_\_/\_\_\_\_\_; \_\_\_\_/\_\_\_\_) Pupils: Equal Unequal  
 Vision: R - 20/\_\_\_\_ L - 20/\_\_\_\_ Corrected: Y N \_\_\_\_\_

<i>Medical</i>	<i>Normal</i>	<i>Abnormal Findings</i>	<i>Initials*</i>
Appearance			
Eyes/Ears			
Nose/Throat			
Lymph Nodes			
Heart - Supine			
Heart - Standing			
Heart - Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males)			
Skin			
<b>Musculoskeletal</b>			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

**CLEARANCE** \* station-based exam only

- Cleared  
 Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

Not cleared for: \_\_\_\_\_  
 Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_  
 \_\_\_\_\_

The following information must be filled in and signed by either a Physician, a Physician Assistant (licensed by a State Board of Physician Assistant Examiners), or a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner will not be accepted.

**Date of Examination:** \_\_\_\_\_

**Name of Physician (print):** \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Signature:** \_\_\_\_\_

Must be completed before a student participates in any practice, before, during, or after school, (both in-season and out-of-season) or games/matches.

**Explain "Yes" answers here:** \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Females Only**