

**Perris Union High School District
Athletic Emergency/Medical Information & Participation Form**

FALL <input type="checkbox"/> Cross Country <input type="checkbox"/> Football <input type="checkbox"/> Girls Tennis <input type="checkbox"/> Boys Water Polo <input type="checkbox"/> Girls Volleyball <input type="checkbox"/> Girls Golf	WINTER <input type="checkbox"/> Basketball <input type="checkbox"/> Soccer <input type="checkbox"/> Wrestling <input type="checkbox"/> Girls Water Polo	SPRING <input type="checkbox"/> Baseball <input type="checkbox"/> Boys Golf <input type="checkbox"/> Softball <input type="checkbox"/> Swimming <input type="checkbox"/> Boys Tennis <input type="checkbox"/> Track <input type="checkbox"/> Boys Volleyball	MULTI <input type="checkbox"/> Cheer <input type="checkbox"/> Team Manager <input type="checkbox"/> Band <input type="checkbox"/> Color Guard <input type="checkbox"/> NJROTC <input type="checkbox"/> OTHER:
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Athlete's Name:		Address:		Today's Date:	
City:	State: CA	Zip Code:	Home Phone:		
Grade:	Age:	Gender:	Date of Birth:	Place of Birth:	
Father/Guardian's Name:			Phone:	Employer:	
Mother/Guardian's Name:			Phone:	Employer:	
Emergency Phone Number:		Cell #:	E-Mail:		
Family Physician:		Phone Number:	School attended previous semester:		
List all schools attended in the last 12 months:					

Medical History Questionnaire- This Section must be completed:

	Y	N		Y	N
1. Are you currently under a doctor's care for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	15. Do you have any trouble breathing before or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	16. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	17. Do you wear glasses or contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you currently taking any medications or pills	<input type="checkbox"/>	<input type="checkbox"/>	18. Do you use any special equipment? (splint, neck rolls, mouth guards, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any allergies? (medicine, bee sting, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	19. Has anyone in your family died of heart problems or sudden death before the age of 50?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever been dizzy or fainted during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	20. Do you only have one working organ of usually paired organs? (eye, kidney, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had chest pains during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have you ever sprained, broken, dislocated, or had repeated swelling or pain of any bones or joints?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	22. Are any of the following currently bothering you? Hand / Wrist / Elbow / Forearm / Hip / Thigh / Knee / Ankle / Shin / Calf / Foot	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	23. Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever had a racing heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	24. Have you ever had any medical problems or injuries? (asthma, mono, diabetes, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	25. Have you had any medical problems since your last evaluation?	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	26. Were there any special instructions or precautions given by the Medical Practitioner?	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	27. What was the date of your tetanus shot?		
14. Have you ever been dizzy or passed out due to the heat?	<input type="checkbox"/>	<input type="checkbox"/>	28. (Women Only) Date of your first menstrual period: When was your last menstrual period? Longest period of time between periods last year?		

Explain all "Yes" answers by question numbers, indicate dates for each item and include any special instructions.

I/we hereby state, to the best of my/our knowledge, the answers to the questions for the medical history questionnaire above are true. I/we understand that by performing this examination, the undersigned physician does not assume responsibility for medical care of this individual. I/we verify that I/we have read and understand all material presented and all information I/we have provided is correct and I/we give permission for my/our child or ward to receive a physical exam and to participate in athletics. In the event reasonable attempts to contact the parent/guardian at the above phone numbers meets with no success, full authorization is given for the administration of any treatment deemed necessary by a medical practitioner, and the transfer of son/daughter or ward to any medical practitioner, and the transfer of my/our son/daughter or ward to any licensed hospital or emergency clinic reasonably accessible. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of school authorities and aforesaid agent(s) to give reasonable care. Facts are provided above concerning the student athlete's medical history which a medical practitioner should know.

Family Health Insurance Co.	Policy ID #
Signature of Athlete	Date:
Signature of Parent or Guardian	Date:

	Blood Pressure	HEENT	Skin	Heart	Lungs	Abdomen	Flexibility/Strength
Normal							
Abnormal							

While this does not constitute a physical nor replace the need for a periodic health evaluation by a family physician, this individual appears to be physically capable of participation in interscholastic sports as of this date except as indicated below.

<input type="checkbox"/> Cleared for sport without restrictions		
<input type="checkbox"/> Cleared with the following restrictions:		
<input type="checkbox"/> Cleared after completing evaluation/rehabilitation for:		
<input type="checkbox"/> Not cleared for participation in athletics		
Doctor's Office Stamp:	Physician's Signature:	Date:

**CONSENT TO PARTICIPATE AND AGREEMENT TO WAIVE LIABILITY, RELEASE,
ASSUME RISK, HOLD HARMLESS AND OBEY RULES AND INSTRUCTIONS**

Parent/Guardian Name: _____

Date: _____

Consent is hereby given for student _____ to participate in athletic sports/activities within the Perris Union High School District. Participation **IS VOLUNTARY** and **IS NOT REQUIRED** as a part of the regular school program.

I am aware that participating, playing, practicing to play or preparing to practice/play in any athletic sport/activity can be a dangerous activity involving **MANY RISKS OF INJURY**. I understand that the dangers and risks of participating, playing, practicing to play or preparing to practice/play in athletic sports/activities include, but are **not limited to**, death, serious neck and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to virtually all internal organs, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the musculoskeletal system, and serious injury or impairment to other aspects of my (or my student's) body, general health and well-being. I understand that the dangers and risks of participating, playing, practicing to play or preparing to practice/play in athletic sports/activities may result not only in serious injury, but in a serious impairment of my (or my student's) future abilities to earn a living, to engage in other business, social and recreational activities, and generally to enjoy life.

In the event of an accident or sudden illness, Perris Union High School District has permission to render whatever emergency medical treatment may be deemed necessary for the above named student. I will assume the cost of ambulance service in the case of an emergency and understand that the district does not pay for ambulance service. I further understand and accept the responsibility for obtaining a written confirmation from the physician indicating that the student may return to practice and competition with his/her team anytime a student is seen by such personnel.

Because of the dangers of participating, playing, practicing to play or preparing to practice/play in athletic sports/activities, I (or on behalf of my student) recognize the importance of following coaches' instructions regarding playing techniques, training and game and other team rules and agree to obey such instructions/rules.

Students are expected to use District transportation when it is provided. It is never permissible for students to transport other students to or from athletic contests. Any other arrangements due to emergency or family circumstances must be requested in writing by the parent/guardian (who has signed this form) the day before the trip and cleared through the school office.

In consideration of the Perris Union High School District permitting me (or my student) to try out for athletic sports/activities and to **ENGAGE IN ALL ACTIVITIES RELATED TO THE TEAM**, including, but **not limited to**, trying out, preparing for, transporting to or from, practicing for, playing or otherwise participating in athletic sports/activities, I (**OR ON BEHALF OF MY STUDENT**) **HEREBY ASSUME ALL RISKS ASSOCIATED WITH PARTICIPATION AND AGREE TO WAIVE LIABILITY AND HOLD THE PERRIS UNION HIGH SCHOOL DISTRICT, ITS EMPLOYEES, AGENTS, REPRESENTATIVES, COACHES, AND ALL VOLUNTEERS HARMLESS FROM ANY AND ALL LIABILITY, ACTIONS, CAUSES OF ACTIONS, DEBTS, CLAIMS, OR DEMANDS OF ANY KIND AND NATURE WHATSOEVER WHICH MAY ARISE BY OR IN CONNECTION WITH MY (OR MY STUDENT'S) PARTICIPATION IN ANY ACTIVITIES RELATED TO THE TEAM.** The terms hereof shall serve as a **RELEASE** and **ASSUMPTION OF RISK** for me, my heirs, estate, executor, administrator, assignees, and for all members of my family.

THE UNDERSIGNED HAS CAREFULLY READ THE FOREGOING RELEASE AND ASSUMPTION OF RISK AGREEMENT AND FULLY UNDERSTANDS IT.

Parent/Guardian Signature

Student Signature

Health Insurance/Student Accident Insurance Carrier*

Policy Number

*If you do not have accident insurance, the district provides forms for you to obtain insurance as required by law. The forms are available at the school office. Insurance must be maintained at all times. Notify the athletic director of cancellation/change in policy.



PERRIS UNION HIGH SCHOOL DISTRICT

"Growing Together Through Education"

ATHLETIC PHYSICAL PACKET

SIGNATURE CONSOLIDATION PAGE

We, the undersigned are fully aware of the information contained in the athletic physical packet. By initialing and signing on this page we confirm our consent to follow the rules and policies of the Perris Union High School District.

Student Record and Media Release Authorization

Parent

Athlete

Athletic Release of Liability

Part 1:

Part 2:

Part 3:

Insurance:

Transportation:

Stadium Turf Agreement:

C.I.F. Sudden Cardiac Arrest:

Concussion Management Protocol

Responsibility to report all injuries

CIF/CDC concussion fact sheet

Concussion is a brain injury

Concussion can affect my ability to perform everyday functions

Symptoms can show up hours or days after the injury

Report suspected teammate concussions

Do not return to play in a game or practice with concussion symptoms

Return to play too soon may increase the chances of a repeat concussion

Repeat concussions can cause permanent brain damage and even death

Impact Consent Form

Impact Consent for Baseline Cognitive Testing

Impact Consent for Post Concussion Cognitive Testing

Name of Parent (Please Print): _____

Parent Signature: _____ Date: _____

Name of Student (Please Print): _____

Student Signature: _____ Date: _____

