

Park High School Sports Programs

Attached is the necessary paperwork that you will need to file before your student is allowed to participate in Park High sports. Students who do not have the following forms signed and on file with the office **will not be allowed to practice**. Participation fees must be paid prior to the first game.

You will need:

- **Medical Insurance Waiver form (Required of all students regardless of sports participation).** This authorizes PHS to seek medical attention should your student be injured during a school sanctioned event. Please sign and return to the Attendance Office. *This form is required of all students who attend PHS as we need permission to seek medical attention should your student get injured during a field trip, class project, club trip, etc.*
- **Livingston School District Concussion Information Sheet.** This form explains the dangers and symptoms of concussions. Please read it carefully and sign Legal Guardian Concussion Statement (on the back of the Medical Insurance Waiver Form). Please remember to *initial all boxes regarding concussions on the back of the Med Waiver form.*
- **Activities Code Form.** This form outlines the rules and guidelines for participation in all Livingston School District activities. Please read through this to understand the rules governing participation in our activities programs. Please read it carefully and sign the Activities Participation Signature Form (at the bottom of the Medical Insurance Waiver Form).
- **Student participation fee.** This onetime fee of \$85 covers participation in all sports regardless of how many sports one is involved in. Pay this fee at the beginning of the school year as this *will not only allow your student to participate in any and all PHS sports programs throughout the year, but also includes free admission for your student to attend all sports home games (except tournaments) during the school year.* PLEASE NOTE your student will not be allowed to play in scheduled games until this fee is paid.
- **Student Activity Drug Testing Policy.** Adopted this year, the policy outlines the drug testing process at PHS. The policy applies to all Livingston School District students in grades 9-12 who are involved in an extracurricular activity. The consent form must be signed by both student and parent.
- **Physical from a qualified physician (completed after May 1, 2018).** Please call our nurse, Sue Harriman, at 222-0448, ext. 210 to make an appointment with the **Ranger Clinic (a service of Livingston Healthcare) at Park High** when fall sports begin in August. **CHP also offers physicals at 222-1111** throughout the summer. Take the attached physical form with you and return it to the Attendance office once it's complete. **PLEASE NOTE** that your doctor's office must give you the completed form back at the time of the visit and it's the parents' responsibility to make sure the form is submitted to the Attendance Office. Doctor's offices **WILL NOT FAX** them.

Please call Regina Wood at 222-1760, Activities Director,
or Melissa Cahoon, Administrative Assistant, at 222-0448
if you have any questions or concerns.

Please go to "parkhigh.org/athletics" and click on the "**Activities Forms Info**" button
for detailed information about this form.



PLEASE NOTE

In an effort to save money on paper, a reference packet explaining each form is available if you need one.

**Or you can go to
[“parkhigh.org/activities”](http://parkhigh.org/activities) to find a
complete explanation of all forms
included in this packet.**

**Thanks for helping us save
precious resources.**



Park High School
 102 View Vista Drive
 Livingston, MT 59047
 Phone: 406-222-0448
 Fax: 406-222-9404

Student Name (Please Print)

 Last

 First

 Grade

 Sport/Activity

2018-19

Medical Insurance Waiver Form

~ This form must be completed and signed to be valid ~

The Livingston School District does not offer a medical insurance program for students. Therefore, it is the responsibility of the parent/guardian of the student to secure medical insurance. In return for the school district allowing your son/daughter to participate in activities you must agree to take full responsibility for medical expenses for your child.

This form must be signed and returned to the office/advisor prior to your son/daughter participating in any activity. I have read and understand the Medical Insurance Waiver and agree to accept responsibility for my child's medical expenses.

Medical Assistance to Injured Students

I hereby authorize School District Number 4 & 1 and its faculty members in charge of my child named below, to obtain all necessary medical care for my child, and I hereby authorize any licensed physician and/or medical personnel to render necessary medical treatments to my child.

 Parent/Guardian (Print)

 Relationship to student

 Parent/Guardian Signature

 Date

Address:

____ / ____ / ____
 Student Birthdate (MM/DD/YY)

 Home Phone

 Cell Phone

 Work Phone

PHS Activities Code
 (must also be signed)



Both my child and I have read the Park High School Activities Code and I understand its contents. We agree to abide by all of the policies described in the Activities Code.

 Parent Name (Please Print)

 Date

 Student Name (Please Print)

 Parent Signature

 Date

 Student Signature

Please go to "parkhigh.org/athletics" and click on the "[Activities Forms Info](#)" button for detailed information about this form.



Student-Athlete & Parent/Legal Guardian Concussion Statement

Because of the passage of the Dylan Steigers' Protection of Youth Athletes Act, schools are required to distribute information sheets for the purpose of informing and educating student-athletes and their parents of the nature and risk of concussion and head injury to student athletes, including the risks of continuing to play after concussion or head injury. Montana law requires that each year, before beginning practice for an organized activity, a student-athlete and the student-athlete's parent(s)/legal guardian(s) must be given an information sheet, and both parties must sign and return a form acknowledging receipt of the information to an official designated by the school or school district prior to the student-athletes participation during the designated school year. The law further states that a student-athlete who is suspected of sustaining a concussion or head injury in a practice or game shall be removed from play at the time of injury and may not return to play until the student-athlete has received a written clearance from a licensed health care provider.

Student-Athlete Name: _____

This form must be completed for each student-athlete, even if there are multiple student-athletes in each household.

Parent/Legal Guardian Name(s): _____

We have read the *Student-Athlete & Parent/Legal Guardian Concussion Information Sheet*.
If true, please check box

After reading the information sheet, I am aware of the following information:

Student-Athlete Initials		Parent/Legal Guardian Initials
	A concussion is a brain injury, which should be reported to my parents, my coach(es), or a medical professional if one is available.	
	A concussion can affect the ability to perform everyday activities such as the ability to think, balance, and classroom performance.	
	A concussion cannot be "seen." Some symptoms might be present right away. Other symptoms can show up hours or days after an injury.	
	I will tell my parents, my coach, and/or a medical professional about my injuries and illnesses.	N/A
	If I think a teammate has a concussion, I should tell my coach(es), parents, or licensed health care professional about the concussion.	N/A
	I will not return to play in a game or practice if a hit to my head or body causes any concussion-related symptoms.	N/A
	I will/my child will need written permission from a licensed health care professional to return to play or practice after a concussion.	
	After a concussion, the brain needs time to heal. I understand that I am/my child is much more likely to have another concussion or more serious brain injury if return to play or practice occurs before concussion symptoms go away.	
	Sometimes, repeat concussions can cause serious and long-lasting problems.	
	I have read the concussion symptoms on the Concussion fact sheet.	

Please Note: Each box MUST be initialed.

Please Note: Each box MUST be initialed.

Signature of Student-Athlete

Date

Signature of Parent/Legal Guardian

Date

Please go to "parkhigh.org/athletics" and click on the "Activities Forms Info" button for detailed information about this form.

NOTE: This form will be valid ONLY DURING your student's participation in an activity/sport.

3350F

Park High School Student Drug Testing Consent Form

Participation in school sponsored co- and extra-curricular activities at Park High School is a privilege. Activity Students carry a responsibility to themselves, their fellow students, their families, their school, and their community to set the highest possible examples of conduct, which includes avoiding the use or possession of illegal drugs. Chemical use of any kind is incompatible with participation in co- and extra-curricular activities at Park High School.

Park High School has adopted the attached Activity Student Drug Testing Policy and this Student Drug Testing Consent for use by all Activity Students as defined in the Policy. This policy explains in more detail the purpose of drug testing and its implementation. The policy also defines "chemical use" and "illegal drugs".

All PHS students are asked to sign this consent form. However, ONLY those students who are involved in a school sponsored activity or club during the school year will be subject to the random selection process for drug testing. Those students who are NOT involved in any school sponsored activities or clubs will NOT be subject to the random selection process for drug testing.

CONSENT BEFORE PARTICIPATION: Each Activity Student shall be provided with a copy of the Activity Student Drug Testing Policy and this Student Drug Testing Consent, which shall be read, signed and dated by the Activity Student, parent or custodial guardian, and coach/sponsor, and returned to the school administration *before* such student shall be eligible to practice or participate in any activities. The Activity Student (and parent/guardian if student is under 18) shall sign this Consent *before* beginning practice or participation in any activities. The consent allows Park High School to obtain a urine sample from each Activity Student if chosen by the selection basis; and at any time based on a reasonable suspicion to be tested for illegal drugs.

Student's Last Name (please print)

First Name

MI

I have been given, read, and understood the "Student Activity Drug Testing Policy" and this "Student Drug Testing Consent". I understand that Park High School enforces the rules applying to the use or possession of illegal drugs as defined in the policy. As a member of a co- and /or extra-curricular activity, I realize that the personal decisions that I make daily in regard to the use or possession of illegal drugs may affect the health and well-being, may endanger those around me, and may reflect negatively upon myself, my family, my activity, my school, and my community. If I choose to violate school policy regarding the use or possession of illegal drugs, I understand I will be subject to discipline and restrictions on my participation as outlined in the Policy. I consent to submit to drug testing in accordance with the Student Activity Drug Testing Policy.

Signature of Student

Date

We have read and understood the "Activity Student Drug Testing Policy" and this "Student Drug Testing Consent". We desire that the student named above participate in the co- and extra-curricular activities of Park High School. We consent to the implementation and enforcement of the policy, and we agree that the student named above will be subject to the policy and will be required to undergo drug testing in order to participate in school activities. We give our consent to drug testing of this student in accordance with the policy and the procedures implementing the policy. We understand the discipline and restrictions on participation that can be enforced against the student for violations as explained in the policy.

Signature of Parent or Guardian

Date

Please go to "parkhigh.org/athletics" and click on the "[Activities Forms Info](#)" button for detailed information about this form.

MHSA CONFIDENTIAL ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION

See Montana High School Association, Article II, Section (3), Physical Exam. A physical examination is required for each student in order to be considered eligible for participation in an Association contest. Physical examinations must be completed prior to the first practice. This examination must be certified by a licensed medical professional acting within the scope and limitations of his/her practice. This certification is valid for a period of one school year. **A physical examination conducted before May 1st is not valid for participation for the following school year.** All information is to remain confidential.

HISTORY – To be completed by the student and parent(s).

QUESTIONNAIRE FOR ATHLETIC PARTICIPATION (PLEASE PRINT)			
Name _____	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Grade _____ Date of Birth _____
Home Address _____	Phone Number _____		
Parent's Name _____	Family Physician _____		
Current School _____	Date _____		
Student Signature _____			

Explain "Yes" answers below. Circle questions to which you don't know the answer.

- | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason? | <input type="checkbox"/> | <input type="checkbox"/> | 25. Do you cough, wheeze, or have difficulty breathing during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have an ongoing medical condition (like diabetes or asthma)? | <input type="checkbox"/> | <input type="checkbox"/> | 26. Is there anyone in your family who has asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? | <input type="checkbox"/> | <input type="checkbox"/> | 27. Have you ever used an inhaler or taken asthma medicine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you taking medicine for ADHD? | <input type="checkbox"/> | <input type="checkbox"/> | 28. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have allergies to medicines, pollens, foods, or stinging insects? | <input type="checkbox"/> | <input type="checkbox"/> | 29. Have you had infectious mononucleosis (mono) within the last month? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever passed out or nearly passed out DURING exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 30. Do you have any rashes, pressure sores, or other skin problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever passed out or nearly passed out AFTER exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 31. Have you had a herpes skin infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had discomfort, pain, or pressure in your chest during exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 32. Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Does your heart race or skip beats during exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 33. Have you been hit in the head and been confused or lost your memory? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Has a doctor ever told you that you have (circle all that apply):
High blood pressure A heart murmur
High cholesterol A heart infection | <input type="checkbox"/> | <input type="checkbox"/> | 34. Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram) | <input type="checkbox"/> | <input type="checkbox"/> | 35. Do you have headaches with exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Has anyone in your family died for no apparent reason? | <input type="checkbox"/> | <input type="checkbox"/> | 36. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Does anyone in your family have a heart problem? | <input type="checkbox"/> | <input type="checkbox"/> | 37. Have you ever been unable to move your arms or legs after being hit or falling? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Has any family member or relative died of heart problems or of sudden death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> | 38. When exercising in the heat, do you have severe muscle cramps or become ill? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Does anyone in your family have Marfan syndrome? | <input type="checkbox"/> | <input type="checkbox"/> | 39. Has a doctor told you that your or someone in your family has sickle cell trait or sickle cell disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever spent the night in a hospital? | <input type="checkbox"/> | <input type="checkbox"/> | 40. Have you had any problems with your eyes or visions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | 41. Do you wear glasses or contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you ever had an injury, like a sprain, muscle or ligament tear or tendonitis that caused you to miss a practice or game: If yes, circle affected area below: | <input type="checkbox"/> | <input type="checkbox"/> | 42. Do you wear protective eyewear, such as goggles or a face shield? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you had any broken or fractured bones, or dislocated joints? If yes, circle below: | <input type="checkbox"/> | <input type="checkbox"/> | 43. Are you happy with your weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below: | <input type="checkbox"/> | <input type="checkbox"/> | 44. Are you trying to gain or lose weight? | <input type="checkbox"/> | <input type="checkbox"/> |

Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand / fingers	Chest
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot / toes

- | | | |
|--|--------------------------|--------------------------|
| 21. Have you ever had a stress fracture? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Do you regularly use a brace or assistive device? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Has a doctor ever told you that you have asthma or allergies? | <input type="checkbox"/> | <input type="checkbox"/> |

FEMALES ONLY

48. Have you ever had a menstrual period?

49. How old were you when you had your first menstrual period? _____

50. How many periods have you had in the last year? _____

Explain "Yes" answers here:

Allergies: _____

Immunizations: (eg, tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis, pneumococcal; meningococcal, varicella) _____

Date of last known tetanus shot: _____

PROVIDER'S PHYSICAL EXAMINATION FORM

Name _____ Date of Birth _____
 Height _____ Weight _____ Pulse _____ BP: Left Arm _____ / _____ Right Arm _____ / _____
 Vision R 20/ _____ L 20/ _____ Corrected: Y N Pupils: Equal _____ Unequal _____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Hernia			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hands/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

*Multiple examiner set-up only.

Notes: _____

CLEARANCE

Cleared without restriction
 Cleared with recommendations for further evaluation or treatment for: _____

 Not cleared for All sports Certain sports _____ Reason: _____
 Recommendations: _____

Name of physician/medical provider [print or type] _____ Date _____
 Address _____ Phone _____
 Signature of physician/medical provider _____

PARENT'S OR GUARDIAN'S PERMISSION AND RELEASE

I certify that the information provided by the student/parent(s) is accurate to the best of my knowledge. I hereby give my consent for the above student to engage in approved athletic activities as a representative of his/her school, except those indicated above by the licensed professional. I also give my permission for the team physician, athletic trainer, or other qualified personnel to have access to information provided here as well as to give first aid treatment to this student at an athletic event in case of injury. If emergency service involving medical action or treatment is required and the parents(s) or guardian(s) cannot be contacted, I hereby consent for the student named above to be given medical care by the doctor or hospital selected by the school.

Typed or printed name of parent or guardian _____ Signature of parent or guardian _____

Date _____ Address _____ Insurance (Company name) _____

Parent's Home Phone _____ Parent's Work Phone _____ Parent's Cell Phone _____ Additional Phone (if any-specify) _____

ALL INFORMATION IS TO REMAIN CONFIDENTIAL

(Updated 3/10)