Park High School
Sports Programs
2019-20

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 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, 2019).** 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 NOTE

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

Or you can go to "parkhigh.org/activities" to find a complete explanation of all form 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

2019 -20
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)

Concussion Form on back ➡

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.	

_____ _____

Signature of Student-Athlete Date

_____ _____

Signature of Parent/Legal Guardian Date

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

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 ☐ Female ☐ Grade _____ Date of Birth _____

Home Address _____ Phone Number _____

Parent's Name _____ Family Physician _____

Current School _____ Date _____

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

	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2. Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	☐
4. Are you taking medicine for ADHD?	☐	☐
5. Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
6. Have you ever passed out or nearly passed out DURING exercise?	☐	☐
7. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
8. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
9. Does your heart race or skip beats during exercise?	☐	☐
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		
11. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)	☐	☐
12. Has anyone in your family died for no apparent reason?	☐	☐
13. Does anyone in your family have a heart problem?	☐	☐
14. Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
15. Does anyone in your family have Marfan syndrome?	☐	☐
16. Have you ever spent the night in a hospital?	☐	☐
17. Have you ever had surgery?	☐	☐
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:	☐	☐
19. Have you had any broken or fractured bones, or dislocated joints? If yes, circle below:	☐	☐
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:	☐	☐

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?	☐	☐
22. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
23. Do you regularly use a brace or assistive device?	☐	☐
24. Has a doctor ever told you that you have asthma or allergies?	☐	☐
25. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
26. Is there anyone in your family who has asthma?	☐	☐
27. Have you ever used an inhaler or taken asthma medicine?	☐	☐
28. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
29. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
30. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
31. Have you had a herpes skin infection?	☐	☐
32. Have you ever had a head injury or concussion?	☐	☐
33. Have you been hit in the head and been confused or lost your memory?	☐	☐
34. Have you ever had a seizure?	☐	☐
35. Do you have headaches with exercise?	☐	☐
36. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
37. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
38. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
39. Has a doctor told you that your or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
40. Have you had any problems with your eyes or visions?	☐	☐
41. Do you wear glasses or contact lenses?	☐	☐
42. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
43. Are you happy with your weight?	☐	☐
44. Are you trying to gain or lose weight?	☐	☐
45. Have anyone recommended you change your weight or eating habits?	☐	☐
46. Do you limit or carefully control what you eat?	☐	☐
47. Do you have any concerns that you would like to discuss with a doctor?	☐	☐
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: _____

Required for School* and Recommended Immunizations: (please check if student is up-to-date): ☐ Hepatitis A; ☐ Hepatitis B; ☐ Human Papillomavirus (HPV); ☐ Influenza; ☐ Measles, Mumps, Rubella (MMR)*; ☐ Meningococcal; ☐ Polio*; ☐ Tetanus/Diphtheria/Pertussis (Tdap)*; ☐ Varicella (Chickenpox)*

Date of last known tetanus shot (Tdap): _____

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

_____ _____

Typed or printed name of Student Signature of Student

☐ 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 4/19)