

SKIATOOK BULLDOGS



ATHLETIC/ACTIVITY PHYSICAL/CONSENT PACKET

(2010-2011)

STUDENT NAME: _____

PARENT OR GUARDIAN NAME(S): _____

CONTACT NUMBER (IN CASE OF EMERGENCY): () _____ - _____ **HM./WK./CELL**

(CIRCLE ONE)

SKIATOOK PUBLIC SCHOOLS

355 S. OSAGE

SKIATOOK, OK 74070

SKIATOOK PUBLIC SCHOOLS

APPROVAL FOR PARTICIPATION IN ATHLETICS/ACTIVITIES

I HEREBY CERTIFY THAT _____ " _____/_____/_____

(STUDENTS NAME)

(BIRTH DATE)

HAS MY APPROVAL TO PARTICIPATE IN ATHLETICS/ACTIVITIES FOR SKIATOOK PUBLIC SCHOOLS. MY STUDENT WISHES TO PARTICIPATE IN THE FOLLOWING SPORTS/ACTIVITIES (PLEASE LIST BELOW):

I ALSO GIVE CONSENT FOR THE ABOVE NAMED STUDENT TO TRAVEL WITH THE COACH OR OTHER REPRESENTATIVES OF THE SCHOOL ON ANY SCHOOL SPONSORED TRIPS. I UNDERSTAND THAT STUDENTS, EVEN WHEN OFF CAMPUS, ARE STILL SUBJECT TO SCHOOL RULES AND REGULATIONS WHEN PARTICIPATING IN ATHLETICS/ACTIVITIES FOR SKIATOOK PUBLIC SCHOOLS.

I UNDERSTAND THAT ANY STUDENT WHO DOES NOT CONDUCT HIMSELF/HERSELF PROPERLY, AS DETERMINED BY THEIR COACH/DIRECTOR/SCHOOL PERSONNEL, MAY BE (1) SENT HOME AT THE PARENT/LEGAL GUARDIAN'S EXPENSE, (2) PROHIBITED FROM PARTICIPATING IN FUTURE ACTIVITIES OF THAT GROUP/TEAM/ORGANIZATION; AND/OR (3) SUBJECT TO OTHER APPROPRIATE DISCIPLINARY ACTION.

I DO UNDERSTAND AND REALIZE THAT IN CASE OF INJURY TO THE STUDENT PARTICIPATING IN SCHOOL ATHLETICS/ACTIVITIES, THE INDEPENDENT SCHOOL DISTRICT OF SKIATOOK, OKLAHOMA AND ITS ASSIGNED PERSONNEL IS NOT LEGALLY LIABLE FOR SUCH INJURY OR ANY EXPENSE INCIDENT THERETO. THE PARENT OR LEGAL GUARDIAN HEREWITH GRANTS PERMISSION FOR SCHOOL EMPLOYEES TO SECURE MEDICAL SERVICES FOR THE ABOVE NAMED STUDENT IF IT IS DEEMED NECESSARY. THE SKIATOOK PUBLIC SCHOOLS AND ITS EMPLOYEES DO NOT ACCEPT LIABILITY FOR PAYMENT OF ANY RESULTING BILL SHOULD THE ABOVE ACTION BE TAKEN.

THE UNDERSIGNED AGREES TO BE RESPONSIBLE FOR THE SAFE RETURN OF ALL ATHLETIC EQUIPMENT ISSUED BY THE SCHOOL TO THE ABOVE NAME STUDENT.

SIGNATURE OF PARENT OR GUARDIAN _____

SIGNATURE OF STUDENT _____

DATE _____/_____/_____

.....
PERMISSION TO ADMINISTER MEDICATION

STUDENT _____ SCHOOL _____

DATE OF BIRTH _____ GRADE _____

SCHOOL PERSONNEL DESIGNATED IN SKIATOOK INDEPENDENT SCHOOL DISTRICT POLICY ARE HEREBY GIVEN MY CONSENT TO ADMINISTER NONPRESCRIPTION MEDICATION TO THE ABOVE DESIGNATED STUDENT.

FURTHER CONSENT IS HEREBY GIVEN TO ADMINISTER PRESCRIPTION MEDICATION TO THE ABOVE DESIGNATED STUDENT WHEN PRESCRIPTION IS PROPERLY LABELED AND IS ACCOMPANIED BY A WRITTEN REQUEST BY THE PROFESSIONAL PERSON WHO PRESCRIBED THE MEDICATION.

SIGNATURE OF PARENT OR GUARDIAN _____

DATE _____/_____/_____

SKIATOOK PUBLIC SCHOOL

EMERGENCY MEDICAL AUTHORIZATION

PART I

***PURPOSE: TO ENABLE PARENTS AND GUARDIANS TO AUTHORIZE THE PROVISION OF EMERGENCY TREATMENT FOR CHILDREN WHO BECOME ILL OR INJURED WHILE UNDER SCHOOL AUTHORITY, WHEN PARENTS OR GUARDIANS CANNOT BE REACHED. THE INFORMATION BELOW IS NEEDED FOR PARTICIPATION IN SCHOLASTIC ACTIVITIES FOR SKIATOOK PUBLIC SCHOOLS. PLEASE COMPLETE THE FORM BELOW WITH ALL APPROPRIATE INFORMATION. THIS FORM MUST BE ACCOMPANIED BY A COMPLETED PHYSICAL FORM BEFORE PARTICIPATING IN ANY ATHLETIC PRACTICE OR ACTIVITY.**

STUDENT INFORMATION

STUDENT: _____ GRADE: _____

ADDRESS: _____

CITY/ZIP: _____ HOME PHONE #: () _____ - _____

FATHER'S NAME: _____ MOTHER'S NAME: _____

FATHER'S WORK PHONE #: () _____ - _____ MOTHER'S WORK PHONE #: () _____ - _____

FATHER'S CELL/PAGER #: () _____ - _____ MOTHER'S CELL/PAGER #: () _____ - _____

ALTERNATE ADULT NAME: _____ PHONE: () _____ - _____

ALTERNATE ADULT NAME: _____ PHONE: () _____ - _____

ADDITIONAL INFORMATION

1. ALLERGIES: (IF NO, SO STATE.)
2. LIST PERTINENT MEDICAL INFORMATION APPLICABLE TO HEART TROUBLE, DIABETES, EPILEPSY, ETC...(IF NO, SO STATE.)
3. DOES STUDENT CARRY MEDICATION? PLEASE LIST NAMES AND PURPOSE FOR USE BELOW...(IF NO, SO STATE.)
 - A. NAME OF MEDICATION (S): _____ PURPOSE: _____
 - B. NAME OF MEDICATION (S): _____ PURPOSE: _____
4. DATE OF LAST TETANUS INJECTIONS: _____
5. DOES STUDENT WEAR GLASSES? _____ CONTACT LENSES? _____ HEARING AID(S)? _____
6. ADDITIONAL MEDICAL INFORMATION

IN THE EVENT ATTEMPTS ARE MADE TO CONTACT ME AND SCHOOL OFFICIALS HAVE BEEN UNABLE TO REACH ME SUCCESSFULLY, I HEREBY GIVE MY CONSENT FOR THE ADMINISTRATION OF TREATMENT DEEMED NECESSARY BY THE FOLLOWING:

PRIMARY CARE PHYSICIAN'S NAME: _____ PHONE# _____

PRIMARY CARE DENTIST'S NAME: _____ PHONE# _____

IN THE EVENT THE DESIGNATED PREFERRED PRACTITIONER IS NOT AVAILABLE, THE STUDENT MAY BE TRANSFERRED TO A HOSPITAL THAT IS REASONABLY ACCESSIBLE. THIS AUTHORIZATION DOES NOT COVER MAJOR SURGERY UNLESS THE MEDICAL OPINIONS OF TWO OTHER LICENSED PHYSICIANS OR DENTISTS, CONCURRING IN THE NECESSITY FOR SUCH SURGERY, ARE OBTAINED PRIOR TO THE PERFORMANCE OF SUCH SURGERY.

DATE: ____/____/____ PARENT/LEGAL GUARDIAN: _____

SIGNATURE

.....

EMERGENCY MEDICAL AUTHORIZATION REFUSAL OF CONSENT

PART II

*****DO NOT COMPLETE IF YOU COMPLETED PART I OF THE EMERGENCY MEDICAL AUTHORIZATION.**

REFUSAL OF CONSENT

I DO NOT GIVE MY CONSENT FOR EMERGENCY MEDICAL TREATMENT OF MY CHILD. IN THE EVENT OF ILLNESS OR INJURY REQUIRING TREATMENT, I WISH THE SCHOOL AUTHORITIES TO TAKE NO ACTION OR TO:

_____/_____/_____ (DATE) _____ (SIGNATURE OF PARENT/GUARDIAN)

.....

INSURANCE RELEASE

STUDENT'S NAME _____ DATE ____/____/_____
DATE OF BIRTH ____/____/_____ AGE _____ SEX _____
ADDRESS _____
CITY _____ ST. _____ ZIP _____
HOME PHONE: () _____-_____ Wk. PHONE () _____-_____ CELL () _____-_____

CHECK THE APPROPRIATE BLANK AND COMPLETE INFORMATION IN ITEM 1, IF APPLICABLE.

____ 1. THIS IS TO CERTIFY THAT MY CHILD IS COVERED BY THE FOLLOWING ACCIDENT INSURANCE,
INSURANCE COMPANY: _____
POLICY NUMBER: _____ GROUP IN NAME OF: _____
NAME OF PARENT OR GUARDIAN WHO IS THE POLICY HOLDER: _____

AND HAS MY PERMISSION TO PARTICIPATE IN ALL SCHOOL-SPONSORED ACTIVITIES. IT IS AGREED THAT THE SCHOOL WILL BE RELIEVED OF ALL RESPONSIBILITY IN THE EVENT OF INJURY.

____ 2. THIS IS TO CERTIFY THAT MY CHILD WILL BE COVERED BY A STUDENT ACCIDENT INSURANCE POLICY PROVIDED BY THE SCHOOL.

____ 3. THIS IS TO CERTIFY THAT WE HAVE NO INSURANCE POLICY WHICH WILL COVER MY/OUR CHILD. HOWEVER, HE HAS MY PERMISSION TO PARTICIPATE IN ALL SCHOOL ACTIVITIES. IT IS FURTHER AGREED THAT THE SCHOOL WILL BE RELIEVED OF ALL RESPONSIBILITY IN THE EVENT OF INJURY.

_____ (SIGNATURE OF PARENT/GUARDIAN) ____/____/_____ (DATE)

OSSAA PHYSICAL EXAMINATION AND PARENTAL CONSENT FORM

PLEASE PRINT

DATE OF EXAM _____

Name _____ Sex _____ Age _____ Date of Birth _____

Grade _____ School _____ Sport(s) _____

Address _____ Phone _____

Personal physician _____ Phone _____

In case of emergency, contact: Name _____

Relationship _____ Phone (H) _____ (W) _____

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

- | | YES | NO | | YES | NO |
|--|--------------------------|--------------------------|---|----------------------------------|------------------------------------|
| 1. Have you had a medical illness or injury since your last check up or sports physical? | <input type="checkbox"/> | <input type="checkbox"/> | 9. Do you cough, wheeze, or have trouble breathing during or after activity? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have an ongoing or chronic illness? | <input type="checkbox"/> | <input type="checkbox"/> | Do you have asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized overnight? | <input type="checkbox"/> | <input type="checkbox"/> | Do you have seasonal allergies that require medical treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | 10. 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"/> |
| 3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler? | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? | <input type="checkbox"/> | <input type="checkbox"/> | Do you wear glasses, contacts, or protective eyewear? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? | <input type="checkbox"/> | <input type="checkbox"/> | 12. Have you ever had a sprain, strain, or swelling after injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a rash or hives develop during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | Have you broken or fractured any bones or dislocated any joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out during or after exercise? | <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"/> |
| 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"/> | If yes, check appropriate box and explain below. | | |
| Do you get tired more quickly than your friends do during exercise? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Head | <input type="checkbox"/> Elbow | <input type="checkbox"/> Hip |
| Have you ever had racing of your heart or skipped heartbeats? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Neck | <input type="checkbox"/> Forearm | <input type="checkbox"/> Thigh |
| Have you had high blood pressure or high cholesterol? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Back | <input type="checkbox"/> Wrist | <input type="checkbox"/> Knee |
| Have you ever been told you have a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Chest | <input type="checkbox"/> Hand | <input type="checkbox"/> Shin/calf |
| Has any family member or relative died of heart problems or of sudden death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Finger | <input type="checkbox"/> Ankle |
| Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Upper arm | | <input type="checkbox"/> Foot |
| Has a physician ever denied or restricted your participation in sports for any heart problems? | <input type="checkbox"/> | <input type="checkbox"/> | 13. Do you want to weigh more or less than you do now? | <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"/> | Do you lose weight regularly to meet weight requirements for your sport? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> | 14. Do you feel stressed out? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been knocked out, become unconscious, or lost your memory? | <input type="checkbox"/> | <input type="checkbox"/> | 15. Record the dates of your most recent immunizations (shots) for: | | |
| Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> | Tetanus _____ Measles _____ | | |
| Do you have frequent or severe headaches? | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis _____ Chickenpox _____ | | |
| Have you ever had numbness or tingling in your arms, hands, legs, or feet? | <input type="checkbox"/> | <input type="checkbox"/> | Explain "Yes" answers here: _____ | | |
| 8. Have you ever become ill from exercising in the heat? | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| | | | _____ | | |
| | | | _____ | | |
| | | | _____ | | |
| | | | _____ | | |

The above information is correct to the best of my knowledge. I hereby give my informed consent for the above-mentioned student to participate in activities. I understand the risk of injury in athletic participation. If my son/daughter becomes ill or is injured, necessary medical care can be instituted by physicians, coaches, trainers or other personnel properly trained.

Signature of parent/guardian _____ Date _____

Signature of athlete _____

(Complete Back Side)

