

# 2020-21 Risk Acknowledgement & Consent to Participate Form Ganado Unified School District Athletic Dept.

**Guardian Instructions:** You and your child must complete this form. At each of the "X's", you, your child, or both must initial or sign your name. Please fill this form out completely. This form is for the Fall, Winter, Spring, and Summer seasons.

**Student Instructions:** You must have this form and a physical evaluation form turned into the Athletic Director before you can practice. No exceptions. For high school student-athletes, you must also complete the Brainbook Concussion Education and Opioid Education courses at <https://academy.azpreps365.com> Upon completion of this form, the Athletic Director will issue you a clearance pass to take to your coach.

GENERAL INFORMATION		STUDENT-ATHLETE T-SHIRT SIZE (BASED ON MEN'S SIZING): S M L XL XXL		
STUDENT-ATHLETE NAME		2020-2021 GRADE	AGE	DATE OF BIRTH
SCHOOL(S) ATTENDED IN THE PAST 12 MONTHS 1.	DATES OF ATTENDANCE		SPORT(S) PLAYED AT PREVIOUS SCHOOL	
2.	DATES OF ATTENDANCE		SPORT(S) PLAYED AT PREVIOUS SCHOOL	
STUDENT EMAIL ADDRESS		GUARDIAN EMAIL ADDRESS		
LEGAL GUARDIAN (SCHOOL MASTER PRIORITY #1)		PHONE NUMBER		
FAMILY MAILING ADDRESS		CITY	STATE	ZIP

MEDICAL INSURANCE INFORMATION		
DO YOU HAVE INSURANCE? <input type="checkbox"/> NO <input type="checkbox"/> YES, our information is below.		
FAMILY PHYSICIAN/HOSPITAL		PHONE NUMBER
INSURANCE COMPANY	POLICY NUMBER	GROUP ID NUMBER

**RELEASE OF LIABILITY**

The Ganado Unified School District and Ganado Athletics Program require all students to travel to and from games via district vehicles. Legal parents/guardians and contract priorities 1 through 4 listed in School Master will be allowed to check out student-athletes after a school sponsored game or event. Once a student-athlete is checked out, they become the sole responsibility of the authorized adult and will be allowed to release students to a third party. You may update your School Master list at any time with a visit to the respective registrar's office.

OFFICE USE ONLY – SCHOOL MASTER INFORMATION FOR COACHES ONLY	
The following are listed in School Master and approved to check out the above student-athlete. All others require approval via communication between the legal guardian and Athletic Director prior to departure or an event.	
SCHOOL MASTER PRIORITY #1/RELATIONSHIP TO STUDENT	PHONE NUMBER
SCHOOL MASTER PRIORITY #2/RELATIONSHIP TO STUDENT	PHONE NUMBER
SCHOOL MASTER PRIORITY #3/RELATIONSHIP TO STUDENT	PHONE NUMBER
SCHOOL MASTER PRIORITY #4/RELATIONSHIP TO STUDENT	PHONE NUMBER

OFFICE USE ONLY – SEASON COMPLETION INFORMATION FOR COACHES ONLY			
Please return all consent forms to the Athletic Department with the following information for your respective sport.			
FALL SPORT	DATES OF ATTENDANCE	CHECK ALL THAT APPLY <input type="checkbox"/> TRYOUTS <input type="checkbox"/> PRE-SEASON ONLY <input type="checkbox"/> COMPETED <input type="checkbox"/> COMPLETED SEASON	COACH SIGNATURE/DATE
WINTER SPORT	DATES OF ATTENDANCE	CHECK ALL THAT APPLY <input type="checkbox"/> TRYOUTS <input type="checkbox"/> PRE-SEASON ONLY <input type="checkbox"/> COMPETED <input type="checkbox"/> COMPLETED SEASON	COACH SIGNATURE/DATE
SPRING SPORT	DATES OF ATTENDANCE	CHECK ALL THAT APPLY <input type="checkbox"/> TRYOUTS <input type="checkbox"/> PRE-SEASON ONLY <input type="checkbox"/> COMPETED <input type="checkbox"/> COMPLETED SEASON	COACH SIGNATURE/DATE

**Insurance Waiver Agreement.** Ganado Unified School District (GUSD) does not recommend any particular insurance company. We do not have access to an insurance plan, which you can participate in. I understand that I, or my insurance company, is solely responsible for payment and/or bills incurred as a result of any injury incurred during the Ganado Unified School District activity. Please initial to the left.

Parent's Initials

**Release and Assumption of Risk.** In consideration of GUSD permitting my child to try out for Ganado Athletics and to engage in all activities related to the team including but not limited to, trying out, practice, or competition in that sport, we hereby assume all risks associated with trainers, and all volunteers harmless from any liability, actions, causes of actions, debts, claims, or demands of any kind in nature whatsoever which may arise by or in connection with my participation in any activities related to the Ganado Teams.

The teams hereof shall serve as a release and assumption of risk for me heirs, estate, executor, administrator, assignees, and for all member of my family. In addition, we consent to practice sessions and travel to and fro the programs. We also agree to treatment as deemed necessary by any medical personnel designated by the program authorities. Please initial to the left.

Parent's Initials

**Agreement to Obey Instruction.** We recognize the importance of following the coaches instructions because of the dangers of participating in sports (ie. Playing techniques, training, other team rules, etc.). We agree to obey all such instructions, as well as to comply with the recommendation of the Sports Medicine Team concerning injury prevention and care. Please initial to the left.

Parent's Initials

**Medical Consent.** In case of a medical emergency, I understand that in the event medical treatment is required, every effort will be made to contact me or the emergency contact person listed. However, if I cannot be reached, I give permission to the staff to secure the services of a licensed physician to provide the care necessary, including hospitalization, anesthesia, injection, or surgery for my child's wellbeing. I hereby agree to indemnify and hold harmless Ganado Unified School District, its schools, and its administration, employees, and coaching staff from any liability. Please initial to the left.

Parent's Initials

**Release of Liability.** I, the undersigned parent/guardian, give permission for my child, a student at Ganado Unified School District, to leave a school-sponsored event by means of private transportation with an authorized adult listed on this form. I release the Ganado Unified School District of all responsibility and liability during such travel. The Ganado Unified School District does not certify that private vehicles have adequate insurance coverage. The student and the authorized adult are still bound to the check-out procedures. This requires a sign-out with his/her coach before leaving the venue. Please initial to the left.

Parent's Initials

PRINT STUDENT'S NAME		PRINT LEGAL GUARDIAN NAME	
STUEDNT'S SIGNATURE	DATE	LEGAL GUARDIAN SIGNATURE	DATE



## 2020-21 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

(The parent or guardian should fill out this form with assistance from the student-athlete)

Exam Date: \_\_\_\_\_

Name: \_\_\_\_\_  
 Home Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Age: \_\_\_\_\_  
 Gender: \_\_\_\_\_  
 Grade: \_\_\_\_\_  
 School: \_\_\_\_\_  
 Sport(s): \_\_\_\_\_  
 Personal Physician: \_\_\_\_\_  
 Hospital Preference: \_\_\_\_\_

In case of emergency contact:  
 Name: \_\_\_\_\_  
 Relationship: \_\_\_\_\_  
 Phone (Home): \_\_\_\_\_  
 Phone (Work): \_\_\_\_\_  
 Phone (Cell): \_\_\_\_\_  
 -----  
 Name: \_\_\_\_\_  
 Relationship: \_\_\_\_\_  
 Phone (Home): \_\_\_\_\_  
 Phone (Work): \_\_\_\_\_  
 Phone (Cell): \_\_\_\_\_

Explain "Yes" answers on the following page.  
 Circle questions you don't know the answers to.

	<b>Y</b>	<b>N</b>																		
1) Has a doctor ever denied or restricted your participation in sports for any reason?																				
2) Do you have an ongoing medical conditional (like diabetes or asthma)?																				
3) Are you currently taking any prescription or nonprescription (over-the-counter) medicines or supplements? (Please specify): _____																				
4) Do you have allergies to medicines, pollens, foods or stringing insects? (Please specify): _____																				
5) Does your heart race or skip beats during exercise?																				
6) Has a doctor ever told you that you have (check all that apply): High Blood Pressure      A Heart Murmur      High Cholesterol      A Heart Infection																				
7) Have you ever spent the night in a hospital?																				
8) Have you ever had surgery?																				
9) Have you ever had an injury (sprain, muscle/ligament tear, tendinitis, etc.) that caused you to miss a practice or game? (If yes, check affected area in the box below in question 11)																				
10) Have you had any broken/fractured bones or dislocated joints? (If yes, check affected area in the box below in question 11):																				
11) Have you had a bone/joint injury that required X-rays, MRI, CT, surgery, injections, rehabilitation physical therapy, a brace, a cast or crutches? (If yes, check affected area in the box below):																				
<table border="0" style="width: 100%;"> <tr> <td>Head</td> <td>Neck</td> <td>Shoulder</td> <td>Upper Arm</td> <td>Elbow</td> <td>Forearm</td> </tr> <tr> <td>Hand/Fingers</td> <td>Chest</td> <td>Upper Back</td> <td>Lower Back</td> <td>Hip</td> <td>Thigh</td> </tr> <tr> <td>Knee</td> <td>Calf/Shin</td> <td>Ankle</td> <td>Foot/Toes</td> <td></td> <td></td> </tr> </table>	Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/Fingers	Chest	Upper Back	Lower Back	Hip	Thigh	Knee	Calf/Shin	Ankle	Foot/Toes				
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Hand/Fingers	Chest	Upper Back	Lower Back	Hip	Thigh															
Knee	Calf/Shin	Ankle	Foot/Toes																	

**Y N**

- 12) Have you ever had a stress fracture?
- 13) Have you ever been told that you have, or have you had an X-ray for atlantoaxial (neck) instability?
- 14) Do you regularly use a brace or assistive device?
- 15) Has a doctor told you that you have asthma or allergies?
- 16) Do you cough, wheeze or have difficulty breathing during or after exercise?
- 17) Is there anyone in your family who has asthma?
- 18) Have you ever used an inhaler or taken asthma medication?
- 19) Were you born without, are you missing, or do you have a nonfunctioning kidney, eye, testicle or any other organ?
- 20) Have you had infectious mononucleosis (mono) within the last month?
- 21) Do you have any rashes, pressure sores or other skin problems?
- 22) Have you had a herpes skin infection?
- 23) Have you ever had an injury to your face, head, skull or brain (including a concussion, confusion, memory loss or headache from a hit to your head, having your "bell rung" or getting "dinged")?
- 24) Have you ever had a seizure?
- 25) Have you ever had numbness, tingling or weakness in your arms or legs after being hit, falling, stingers or burners?
- 26) While exercising in the heat, do you have severe muscle cramps or become ill?
- 27) Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?
- 28) Have you ever been tested for sickle cell trait?
- 29) Have you had any problems with your eyes or vision?
- 30) Do you wear glasses or contact lenses?
- 31) Do you wear protective eyewear, such as goggles or a face shield?
- 32) Are you happy with your weight?
- 33) Are you trying to gain or lose weight?
- 34) Has anyone recommended you change your weight or eating habits?
- 35) Do you limit or carefully control what you eat?
- 36) Do you have any concerns that you would like to discuss with a doctor?

**Females Only**

**Explain "Yes" Answers Here**

	<b>Y</b>	<b>N</b>
37) Have you ever had a menstrual period?		
38) How old were you when you had your first menstrual period?		_____
39) How many periods have you had in the last year?		_____



## 2020-21 ANNUAL PREPARTICIPATION PHYSICAL EXAMINATION

The physician should fill out this form with assistance from the parent or guardian.)

Student Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

### Patient History Questions: Please Tell Me About Your Child...

	Y	N
1) Has your child fainted or passed out DURING or AFTER exercise, emotion or startle?		
2) Has your child ever had extreme shortness of breath during exercise?		
3) Has your child had extreme fatigue associated with exercise (different from other children)?		
4) Has your child ever had discomfort, pain or pressure in his/her chest during exercise?		
5) Has a doctor ever ordered a test for your child's heart?		
6) Has your child ever been diagnosed with an unexplained seizure disorder?		
7) Has your child ever been diagnosed with exercise-induced asthma not well controlled with medication?		

### Family History Questions: Please Tell Me About Any Of The Following In Your Family...

	Y	N
8) Are there any family members who had sudden/unexpected/unexplained death before age 50? (including SIDS, car accidents, drowning or near drowning)		
9) Are there any family members who died suddenly of "heart problems" before age 50?		
10) Are there any family members who have unexplained fainting or seizures?		
11) Are there any relatives with certain conditions, such as:		
<b>Y</b> <b>N</b>		
Enlarged Heart		
Hypertrophic Cardiomyopathy (HCM)		
Dilated Cardiomyopathy (DCM)		
Heart Rhythm Problems		
Long QT Syndrome (LQTS)		
Short QT Syndrome		
Brugada Syndrome		
Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT)		
Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)		
Marfan Syndrome (Aortic Rupture)		
Heart Attack, Age 50 or Younger		
Pacemaker or Implanted Defibrillator		
Deaf at Birth		

### Explain "Yes" Answers Here

I hereby state that, to the best of my knowledge, my answers to all of the above questions are complete and correct. Furthermore, I acknowledge and understand that my eligibility may be revoked if I have not given truthful and accurate information in response to the above questions.

\_\_\_\_\_  
 Signature of Athlete

\_\_\_\_\_  
 Signature of Parent/Guardian

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature of MD/DO/ND/NMD/NP/PA-C/CCSP

\_\_\_\_\_  
 Date



## 2020-21 ANNUAL PREPARTICIPATION PHYSICAL EXAMINATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 % Body Fat (optional): \_\_\_\_\_ Pulse: \_\_\_\_\_  
 BP: \_\_\_\_ / \_\_\_\_ (\_\_\_\_ / \_\_\_\_, \_\_\_\_ / \_\_\_\_)  
 Corrected: Y N  
 Vision: R20/\_\_\_\_ L20/\_\_\_\_  
 Pupils: Equal Unequal

	Normal	Abnormal Findings	Initials *
<b>Medical</b>			
Appearance			
Eyes/Ears/Throat/Nose			
Hearing			
Lymph Nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary &			
Skin			
<b>Musculoskeletal</b>			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hands/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			

\* - Multi-examiner set-up only  
 & - Having a third party present is recommended for the genitourinary examination

**NOTES:**

Cleared Without Restriction

Cleared With Following Restriction: \_\_\_\_\_

Not Cleared For: All Sports Certain Sports: \_\_\_\_\_ Reason: \_\_\_\_\_

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

Name of Physician (Print/Type): \_\_\_\_\_ Exam Date: \_\_\_\_\_

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

Signature of Physician: \_\_\_\_\_, MD/DO/ND/NMD/NP/PA-C/CCSP

## Arizona Interscholastic Association, Inc. Mild Traumatic Brain Injury (MTBI) / Concussion Annual Statement and Acknowledgement Form

I, \_\_\_\_\_ (student), acknowledge that I have to be an active participant in my own health and have the direct responsibility for reporting all of my injuries and illnesses to the school staff (e.g., coaches, team physicians, athletic training staff). I further recognize that my physical condition is dependent upon providing an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries and/or disabilities experienced before, during or after athletic activities.

### By signing below, I acknowledge:

- My institution has provided me with specific educational materials including the CDC Concussion fact sheet (<http://www.cdc.gov/concussion/HeadsUp/youth.html>) on what a concussion is and has given me an opportunity to ask questions.
- I have fully disclosed to the staff any prior medical conditions and will also disclose any future conditions.
- There is a possibility that participation in my sport may result in a head injury and/or concussion. In rare cases, these concussions can cause permanent brain damage, and even death.
- A concussion is a brain injury, which I am responsible for reporting to the team physician or athletic trainer.
- A concussion can affect my ability to perform everyday activities, and affect my reaction time, balance, sleep, and classroom performance.
- Some of the symptoms of concussion may be noticed right away while other symptoms can show up hours or days after the injury.
- If I suspect a teammate has a concussion, I am responsible for reporting the injury to the school staff.
- I will not return to play in a game or practice if I have received a blow to the head or body that results in concussion related symptoms.
- I will not return to play in a game or practice until my symptoms have resolved AND I have written clearance to do so by a qualified health care professional.
- Following concussion the brain needs time to heal and you are much more likely to have a repeat concussion or further damage if you return to play before your symptoms resolve.

Based on the incidence of concussion as published by the CDC the following sports have been identified as high risk for concussion; baseball, basketball, diving, football, pole vaulting, soccer, softball, spiritline and wrestling.

I represent and certify that I and my parent/guardian have read the entirety of this document and fully understand the contents, consequences and implications of signing this document and that I agree to be bound by this document.

Student Athlete:

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or legal guardian must print and sign name below and indicate date signed:

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## 2020-21 CONSENT TO TREAT FORM

Parental consent for minor athletes is generally required for sports medicine services, defined as services including, but not limited to, evaluation, diagnosis, first aid and emergency care, stabilization, treatment, rehabilitation and referral of injuries and illnesses, along with decisions on return to play after injury or illness. Occasionally, those minor athletes require sports medicine services before, during and after their participation in sport-related activities, and under circumstances in which a parent or legal guardian is not immediately available to provide consent pertaining to the specific condition affecting the athlete. In such instances it may be imperative to the health and safety of those athletes that sports medicine services necessary to prevent harm be provided immediately, and not be withheld or delayed because of problems obtaining consent of a parent/guardian.

Accordingly, as a member of the Arizona Interscholastic Association (AIA), GANADO UNIFIED SCHOOL DISTRICT (name of school or district) requires as a pre-condition of participation in interscholastic activities, that a parent/guardian provide written consent to the rendering of necessary sports medicine services to their minor athlete by a qualified medical provider (QMP) employed or otherwise designated by the school/district/AIA, to the extent the QMP deems necessary to prevent harm to the student-athlete. It is understood that a QMP may be an athletic trainer, physician, physician assistant or nurse practitioner licensed by the state of Arizona (or the state in which the student-athlete is located at the time the injury/illness occurs), and who is acting in accordance with the scope of practice under their designated state license and any other requirement imposed by Arizona law. In emergency situations, the QMP may also be a certified paramedic or emergency medical technician, but only for the purpose of providing emergency care and transport as designated by state regulation and standing protocols, and not for the purpose of making decisions about return to play.

### PLEASE PRINT LEGIBLY OR TYPE

"I, \_\_\_\_\_, the undersigned, am the parent/legal guardian of, \_\_\_\_\_, a minor and student-athlete at GANADO UNIFIED SCHOOL DISTRICT (name of school or district) who intends to participate in interscholastic sports and/or activities.

I understand that the school/district/AIA employs or designates QMP's (as defined above) to provide sports medicine services (as also defined above) to the school's interscholastic athletes before, during or after sport-related activities, and that on certain occasions there are sport-related activities conducted away from the school/district facilities during which other QMP's are responsible for providing such sports medicine services. I hereby give consent to any such QMP to provide any such sports medicine services to the above-named minor. The QMP may make decisions on return to play in accordance with the defined scope of practice under the designated state license, except as otherwise limited by Arizona law. I also understand that documentation pertaining to any sports medicine services provided to the above-named minor, may be maintained by the QMP. I hereby authorize the QMP who provides such services to the above-named minor to disclose such information about the athlete's injury/illness, assessment, condition, treatment, rehabilitation and return to play status to those who, in the professional judgment of the QMP, are required to have such information in order to assure optimum treatment for and recovery from the injury/illness, and to protect the health and safety of the minor. I understand such disclosures may be made to above-named minor's coaches, athletic director, school nurse, any classroom teacher required to provide academic accommodation to assure the student-athlete's recovery and safe return to activity, and any treating QMP.

If the parent believes that the minor is in need of further treatment or rehabilitation services for the injury/illness, the minor may be treated by the physician or provider of his/her choice. I understand, however, that all decisions regarding same day return to activity following injury/illness shall be made by the QMP employed/designated by the school/district/AIA.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_