Mountain Shadows Middle School

30401 Reservoir Ave. Nuevo, California 92567
951-928-3836
Daryl Drinkwater, Principal
Lesli Cheers, Athletic Advisor

ATHLETIC PACKET 2017-18

STUDENT NAME (First and Last): _____

Grade: 7 8 (circle one)

INCLUDE A COPY OF INSURANCE CARD

OFFICE USE ONLY

COMPLETED DATE:	MISSING ITEMS:

DATE:	DATE:	DATE:	DATE:
GPA:	GPA:	GPA:	GPA:

Player's Donation: _____ (amount) DATE: _____
Water Cases: _____ (amount) DATE: _____

ATHLETE CODE OF ETHICS

Athletics is an integral part of Mountain Shadow Middle School's total educational program. All school activities, curricular and extra-curricular, in the classroom and on the playing field/court, must be congruent with the school's stated goals and objectives established for the intellectual, physical, social and moral development of its students. It is within this context that the following Athlete Code of Ethics is presented.

As an athlete, I understand that it is my responsibility to:

1. Place academic achievement as the highest priority by maintaining a minimum 2.0 grade point average.
2. Show respect for teammates, opponents, officials and coaches. No athlete shall disrespect, threaten or yell at an official, player (own/opponent) or other adult.
3. Respect the integrity and judgment of game officials. No athlete shall challenge an official's call.
4. Exhibit fair play, sportsmanship and proper conduct on and off the playing field/court.
5. Maintain a high level of safety awareness. This includes respecting all equipment and using it safely and appropriately.
6. Refrain from the use of profanity, vulgarity and other offensive language and gestures.
7. Adhere to the established rules and standards of the game to be played.
8. Refrain from the use of alcohol, tobacco, illegal and non-prescriptive drugs, anabolic steroids or any substance to increase physical development or performance that is not approved by the United States Food and Drug Administration, Surgeon General of the United States or American Medical Association.
9. Know and follow all state, league and school athletic rules and regulations as they pertain to eligibility and sports participation.
10. Win with character, lose with dignity.
11. Violations of this CODE OF ETHICS could result in game suspensions or removal from the athletic team.

Signature of Parent Date

Signature of Athlete School Date

Athlete's Name Printed

PARENT CODE OF ETHICS

Athletics is an integral part of Mountain Shadows Middle School's total educational program. All school activities, curricular and extra-curricular, in the classroom and on the playing field/court, must be congruent with the school's stated goals and objectives established for the intellectual, physical, social and moral development of its students. It is within this context that the following Athlete Code of Ethics is presented.

As a parent, I understand that it is my responsibility to:

1. **Place my child's academic achievement as the highest priority by helping him/her maintain a minimum 2.0 grade point average.**

2. **Show respect for all players, officials, coaches and other adults. No parent shall disrespect, threaten, yell at or attack (verbally or physically) an official, player, coach or other adult.**

3. **Respect the integrity and judgment of game officials. No parent shall challenge an official's call or show objectionable dissent about an official's decision.**

4. **Exhibit fair play, sportsmanship and proper conduct before, during and after the athletic event.**

5. **Refrain from the use of profanity, vulgarity and other offensive language and gestures.**

6. **Know and follow all state, league and school athletic rules and regulations as they pertain to eligibility and sports participation for my son/daughter.**

7. **Teach my athlete how to win with character and lose with dignity.**

8. **Violations of this CODE OF ETHICS could result in removal from the current athletic event and possible suspension from attending future athletic events.**

Signature of Parent **Name (Printed)** **Date**

Athlete's Name (Printed)

Parent/Athlete Concussion Information Sheet

A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by bump, blow, or jolt to the head or body that causes the head and brain to move rapidly back and forth. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

Did You Know?

- Most concussions occur *without* loss of consciousness.
- Athletes who have, at any point in their lives, had a concussion have an increased risk for another concussion.
- Young children and teens are more likely to get a concussion and take longer to recover than adults.

WHAT ARE THE SIGNS AND SYMPTOMS OF CONCUSSION?

Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury.

If an athlete reports ***one or more*** symptoms of concussion listed below after a bump, blow, or jolt to the head or body, s/he should be kept out of play the day of the injury and until a health care professional, experienced in evaluating for concussion, says s/he is symptom-free and it's OK to return to play.

SIGNS OBSERVED BY COACHING STAFF	SYMPTOMS REPORTED BY ATHLETES
Appears dazed or stunned	Headache or "pressure" in head
Is confused about assignment or position	Nausea or vomiting
Forgets an instruction	Balance problems or dizziness
Is unsure of game, score, or opponent	Double or blurry vision
Moves clumsily	Sensitivity to light
Answers questions slowly	Sensitivity to noise
Loses consciousness *(even briefly)*	Feeling sluggish, hazy, foggy, or groggy
Shows mood, behavior, or personality changes	Concentration or memory problems
Can't recall events *prior* to hit or fall	Confusion
Can't recall events *after* hit or fall	Just not "feeling right" or "feeling down"

TRANSPORTATION AUTHORIZATION and PERSONAL INFORMATION

Transportation Authorization

I, _____, am the legal guardian of _____. He/she has my permission to participate in athletics with CREATIVE BRAIN LEARNING and MOUNTAIN SHADOW MIDDLE SCHOOL and to be transported and supervised by authorized persons throughout the school year. As stated in California Education Code, Section 35330, I understand that I hold Nuview Union School District, its officers, agents, and employees harmless from any and all liability or claims, which may arise out of or in connection with my child's participation in athletic events and the transportation to/from it.

_____ _____

Signature of Legal Guardian Date

Personal Information

_____ _____ _____

Student Last Name First Name Middle Name

Age: _____ Date of Birth: _____ Gender (circle one): M F

Grade Level (circle one): 7 8

_____ _____

Home Address City State Zip Home Phone #

_____ _____ _____

Fathers Name Work Phone # Cell Phone #

_____ _____ _____

Mothers Name Work Phone # Cell Phone #

Who does the student live with? [ ] Both parents [ ] Father [ ] Mother [ ] Legal Guardian

[ ] Other _____

INFORMED CONSENT
AWARENESS OF SPORTS INJURY RISK
WARNING AND AGREEMENT

By its very nature, competitive athletics can put students in situations in which SERIOUS, CATASTROPHIC, and perhaps FATAL accidents could occur.

Students and parents/guardians must assess the risks involved in such participation and make their choice to participate in spite of those risks. No amount of instruction, precaution or supervision will totally eliminate all risk of injury. Just as driving an automobile involves choice of risk, participation in athletics is inherently dangerous. The obligation of parents and students in making this choice to participate cannot be over-stated.

By granting permission to your son/daughter to participate in athletic competition, a parent or guardian acknowledges that playing or practicing in any sport can be a dangerous activity involving MANY RISKS OF INJURY. Both the athlete and parent must understand that the dangers and risks of playing or practicing include but are not limited to: death, paralysis, brain damage, serious injury to any of the internal organs, bones, and/or soft tissue.

Because of the dangers of participating in sports, we (parent and player) recognize the importance of following the coaches' instructions regarding playing techniques, training, equipment and other team rules, etc., both in competition and practice, and agree to obey such instructions. We also recognize that conditioning, nutrition, proper techniques, safety procedures, and well-fitting equipment are important aspects of this program. Each player is expected to follow the directions of the coaches.

It is understood that even though protective equipment is worn by an athlete, when needed, the possibility of an accident still remains. Creative Brain Learning and Nuview Union School District does not assume any responsibility when an accident occurs. If, in the judgment of any representative of the school, the below named student should need immediate care and treatment as a result of any injury or sickness, I do hereby authorize and consent to such care and treatment as may be given to said student by any physician, athletic trainer, nurse, or school representative. I do hereby agree to indemnify and hold harmless the school and any school or medical representatives from any claim by any person on account of such care and treatment of said student.

The school requires that both the athlete and the parent sign and date below, acknowledging that they have read the above statement and understand it thoroughly. This paper, with signature, will be kept on file with the administration. I have read and understand the information above and give my son/daughter permission to participate.

_____ _____ _____

Parent/Guardian Signature Date Phone number

_____ _____

Athlete's Signature Athlete's Name (Print)

MEDICAL ISSUES: _____

Mountain Shadows Middle School Athletic Department Emergency Travel Cards

****PARENTS, PLEASE COMPLETE BOTH TRAVEL CARDS****

Athletic Department Emergency Travel Card – School Year _____

Name _____ Age _____ Date of Birth _____ SS# _____

Address _____ City _____ Zip _____

Parents' Names _____ Home Phone _____

Father's Work Phone _____ Father's Mobile Phone _____

Mother's Work Phone _____ Mother's Mobile Phone _____

Emergency Contact Name _____ **Relationship** _____ **Phone** _____

Preferred Hospital in Emergency _____

Insurance Carrier _____ **Policy Number** _____

Allergies or Conditions _____

Athletic Department Emergency Travel Card – School Year _____

Name _____ Age _____ Date of Birth _____ SS# _____

Address _____ City _____ Zip _____

Parents' Names _____ Home Phone _____

Father's Work Phone _____ Father's Mobile Phone _____

Mother's Work Phone _____ Mother's Mobile Phone _____

Emergency Contact Name _____ **Relationship** _____ **Phone** _____

Preferred Hospital in Emergency _____

Insurance Carrier _____ **Policy Number** _____

Allergies or Conditions _____

AUTHORIZATION OF CONSENT FOR EMERGENCY TREATMENT OF MINOR

Please list the name and phone numbers of the parent/guardian to be notified in an emergency situation as well as an alternate emergency contact and your family physician.

Student's Name: _____ M or F Date of Birth:_____

Address: _____

Parent/Guardian: _____ **Cell Phone #:** _____

Home Phone #: _____ Business Phone #: _____

EMERGENCY Contact: _____ **Cell Phone #:** _____

Home Phone #: _____ Business Phone #: _____

Physician (Name): _____ Phone #:_____

I hereby authorize and give consent for the above named student (hereafter referred to as "my child") to compete in sports with/for Creative Brain Learning at Mountain Shadows Middle School. I authorize my child to travel with and be supervised by a representative of Creative Brain Learning and/or Nuview Union School District on any trips. I understand that the Creative Brain Learning and Nuview Union School District assumes any responsibility in case an accident occurs. I will not hold liable Creative Brain Learning and/or Nuview Union School District, its officers or employees for medical aid rendered and will reimburse Creative Brain Learning and/or Nuview Union School District for medical or other expenses incurred in my child's care.

If, in the judgment of any representatives of Creative Brain Learning and/or Nuview Union School District, my child needs immediate care and treatment as a result of any injury or illness, I do hereby request, authorize, and consent to such care and treatment as may be given to my child by any physician, trainer, nurse, hospital, or school representative. I authorize any x-ray examination, anesthetic, medical or surgical diagnosis and treatment and emergency hospital care which is deemed advisable by and is rendered under the supervision of any member of the medical staff and emergency room staff licensed under provisions of the Medicine Practice Act and on the staff of any hospital holding a current license to operate from the State of California Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital emergency care being required but is given to provide authority and power to render care which the aforementioned adults in the exercise of his/her best judgment may deem advisable. It is understood that every effort shall be made to contact me prior to rendering treatment to my child, but that any of the above treatment will not be withheld if I cannot be reached. I will assume financial responsibility for any and all treatment rendered to my child. Creative Brain Learning and/or Nuview Union School District, its employees or agents, or volunteers will not be responsible for such costs.

This authorization is given pursuant to California Civil Code Section 25.8 and remains effective until the end of the school year, unless revoked sooner in writing and delivered to the Creative Brain Learning Site Coordinator and/orPrincipal at Mountain Shadows Middle School. In accordance with Education Code, Section 49407, I, the parent/guardian hereby agree to waive and hold harmless Creative Brain Learning and/or Nuview Union School District, as well as any person whosoever provided care and treatment of my child, from all claims against them for injury, accident, illness, or death occurring to my child by reason of participation in athletics.

List any medical conditions or allergies:

_____

_____

_____ _____

Signature of Parent/Guardian **Date**

Athletic Insurance Coverage Verification

In accordance with California Education Code 32221.5, Creative Brain Learning and Nuview Union School District is required to inform you of the following information:

Under state law, school districts are required to ensure that all members of school athletic teams have accidental injury insurance that covers medical and hospital expenses. This insurance requirement can be met by the school district offering insurance or other health benefits that cover medical and hospital expenses. Some pupils may qualify to enroll in no-cost or low-cost local, state, or federally sponsored health insurance programs. Information about these programs may be obtained by contacting:

(1) The Healthy Families Program
(2) Medi-Cal
(3) Any other comparable no-cost or low-cost local, state, or federally sponsored health insurance program.

In accordance with California Education Code, before your son or daughter is eligible to participate in athletics, you must provide proof of insurance coverage for him/her. Please read the following form carefully, and if you currently have the required insurance coverage for your son/daughter, please sign this form and PROVIDE PROOF OF SUCH COVERAGE **by attaching a copy of your insurance membership identification card.**

I, _____ do hereby declare that _____
(Name of Parent/Guardian) (Name of Student)

is insured in accordance with California Education Code, through:

Insurance Company Name: _____

Policy Number: _____

I understand that the aforesaid California Education Code requires that the above named insurance coverage apply to the above named student as he/she is a member of an athletic team and/or is a non-competitor who performs duties in connection with athletic events while he/she is engaged in or preparing for an athletic event promoted under the sponsorship or the arrangement of the Creative Brain Learning and/or Nuview Union School District or Associated Student Body (ASB), whether he/she is on the way to/from the school or other place of instruction, as well as at the place of the athletic event.

I further understand that the above insurance covers doctors' services and hospitalization. Furthermore, I will assume the cost of ambulance service in case of emergency. I understand that the school does not pay for ambulance services. I accept full responsibility for the cost of treatment for any injury which my child may suffer while taking part in the MSMS athletics program. I will continue to keep this policy in force throughout the sports season(s) my son/daughter is participating in.

My signature on this form signifies that I, the parent/guardian of the above named athlete, certify that this information is correct.

_____
Parent/Guardian Name (Please Print)

_____ _____
Parent/Guardian Signature Date

MOUNTAIN SHADOWS MIDDLE SCHOOL
30401 Reservoir Avenue, Nuevo, CA 92567
Phone: (951) 928-3836 Fax: (951) 928-3015

ANNUAL PREPARTICIPATION PHYSICAL EXAMINATION- PARENTS FILL THIS OUT

Name: _____ Date: _____ Grade: _____

Address: _____ Phone: _____

Sex:_____ DOB: _____ Glasses/Contacts: Yes / No Age: _____

Personal Physician:_____ Phone: _____

Emergency Contact: _____ Relationship:_____ Phone (1):_____ Phone (2):_____

Explain "Yes" answers on the back of this sheet. Circle questions you don't know the answers to. *Any Yes answer to questions 1, 2, 5, 7, 11, or 17 may require further medical evaluation. Written clearance you're your medical provider is required before any participation in practices or contests.*

1. Have you had a medical illness or injury since your last check up or sports physical?
☐Yes ☐No

2. Have you been hospitalized overnight in the past year? ☐Yes ☐No

3. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?
☐Yes ☐No

4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? ☐Yes ☐No

5. Have you ever passed out during or after exercise?
☐Yes ☐No

6. Have you ever been dizzy during or after exercise?
☐Yes ☐No

7. Have you ever had chest pain during or after exercise?
☐Yes ☐No

8. Do you get tired more quickly than your friends do during exercise?
☐Yes ☐No

9. Have you ever had racing of your heart or skipped heartbeats?
☐Yes ☐No

10. Have you had high blood pressure or high cholesterol?
☐Yes ☐No

11. Have you ever been told you have a heart murmur?
☐Yes ☐No

12. Has any family member or relative died of heart problems or of sudden unexpected death before age 50?
☐Yes ☐No

13. Has any family member been diagnosed with enlarged heart, hypertrophic cardiomyopathy, long QT syndrome, Marfan's syndrome, or abnormal heart rhythm)?
☐Yes ☐No

14. Have you had a severe viral infection (for example, Myocarditis or mononucleosis) within the last month?
☐Yes ☐No

15. Has a physician ever denied or restricted your participation in sports for any heart problems?
☐Yes ☐No

16. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?
☐Yes ☐No

17. Have you ever had a head injury or concussion?
☐Yes ☐No

18. Have you ever been knocked out, become unconscious, or lost your memory?
☐Yes ☐No

If yes, how many times?_____

When was the last concussion?_____

How severe was each one? (Explain on back)

19. Have you ever had a seizure?
☐Yes ☐No

20. Do you have frequent or severe headaches?
☐Yes ☐No

21. Have you ever had numbness or tingling in your arms, hands, legs, or feet? ☐Yes ☐No

22. Have you ever had a stinger, burner, or pinched nerve?
☐Yes ☐No

23. Have you ever become ill from exercising in the heat?
☐Yes ☐No

24. Have you ever gotten unexpectedly short of breath with exercise?
☐Yes ☐No

25. Do you cough, wheeze, or have trouble

Name _____ DOB _____

Height:_____ Weight:_____ Pulse:_____ BP: _____

Vision: R 20/_____ L 20/_____ Glasses/Contacts: Yes / No Pupils: Equal_____ Unequal _____

	Normal	Abnormal Findings	Initials*
Medical			
Appearance			
Skin			
Eyes/Ears/Nose			
Throat/ Oropharynx			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia/ Hernia			
Musculoskeletal			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			

- **Cleared without restrictions**
- **Cleared, with recommendations for further evaluation/treatment/rehabilitation for:** _____
  _____
- Not Cleared for: ☐ All Sports ☐ Certain Sports:_____

Reason: _____

Recommendations: _____

Allergies/Medications: _____

Other Information: _____

Name of medical provider (print) _____ **Date** _____

Address _____ **Phone** _____

Signature of medical provider_____ **MD/NP/PA-C/DC**

Revised 08-17