DSMS Athletics

Student-Athlete Name: _____

Desert Shadows Middle School Diamondbacks

Revised 07/05/16 *(jm)*

DESERT SHADOWS MIDDLE SCHOOL
340 BLVD. DEL REY DAVID
NOGALES, ARIZONA 85621
(520) 377-2646 FAX (520) 377-2674

Joan Molera	**Chris Miranda**	**Kristi Beach**	**Elba Orozco**
Principal	Assistant Principal	Athletic Director	Athletic Secretary

Dear Student-Athlete/Club Participant:

Congratulations on choosing to participate in athletics/clubs at Desert Shadows Middle School! The privilege to participate in athletics/clubs carries with it many responsibilities, the first of which is becoming eligible academically. Grades are checked every two weeks to make sure you are as successful in the classroom as you are on the field.

Prior to joining DSMS athletics/clubs, you must complete the necessary release forms contained in this packet yearly. In order to be authorized to participate, you must return the enclosed packet (and a copy of your insurance card) to the Student Services Office. Specifically:

- ✔ Parents must complete pp. 3-6:

  Parent Consent Form - Gives student parental permission to participate in sports programs and clubs.

  Proof of Insurance – Must provide a copy of current insurance or purchase the "school insurance"

  Student Health History – Documents previous and current conditions and / or injuries

- ✔ Your child's doctor must complete pp. 7-8:
  (Only physicians from the Unites States are authorized to complete the Physical Examination Summary page as per NUSD #1 policy).

  Annual Health Update - Documents information regarding previous injuries or conditions that could pose a hazard to the student athlete while participating in sports programs.

  Physical Examination Summary – Includes a full physical exam and signed clearance from a medical provider

As soon as you return this packet (and a copy of your insurance card) to the Student Services Office, you will receive a release slip to give to your coach. At that time you are released to practice.

Good luck as a Desert Shadows Middle School student-athlete. Go Diamondbacks!

PARENT CONSENT FORM

This form must be completed annually **by the parent/guardian** to participate in any DSMS sport

Student's Name: _____ Date of Birth: _____

Grade: _____ Age: _____

Please circle the sports you will be trying out for / participating in:

CHEERS	POM POMS	CROSS-COUNTRY	VOLLEYBALL	FOOTBALL
TENNIS	SOCCER	BASKETBALL	SOFTBALL	BASEBALL
TRACK	OTHER (specify):	_____		

Parent(s) / Guardian(s) Names: _____

Address: _____

City/State/Zip: _____

Father's Daytime Phone: _____ Cell: _____

Mother's Daytime Phone: _____ Cell: _____

EMERGENCY NOTIFICATION: (To be notified when parents cannot be contacted)

Contact 1:
Name: _____ Relation: _____ Phone #: _____

Contact 2:
Name: _____ Relation: _____ Phone #: _____

Family Doctor: _____ Phone #: _____

Known Allergies / Conditions: _____

Be it known that I the undersigned parent(s) or legal guardian of the above named student do hereby give consent and authorization for designated Desert Shadows Middle School personnel to render necessary emergency first aid treatment in addition to securing any and all required medical aid or assistance to include ambulance service if a parent or legal guardian cannot be immediately contacted in the event the above named student should be injured or stricken ill during a school activity.

Furthermore, I hereby give and grant onto any medical or hospital personnel my consent and authorization to render necessary emergency first aid treatment in addition to securing any and all required medical aid or assistance including ambulance service if a parent or guardian cannot be immediately contacted in the event the above named student should be injured or stricken ill during a school activity.

Father's Signature: _____ Date: _____

Mother's Signature: _____ Date: _____

PROOF OF INSURANCE

This form must be completed annually **by the parent/guardian** to participate in any sport.

Student's Name: _____ Date: _____

Address: _____ Phone #: _____

PARENTS: PLEASE ATTACH A COPY OF YOUR INSURANCE CARD **(front and back)** TO THIS PACKET.

Note: If you do not have insurance, you must purchase "school insurance" (Myers-Stevens & Toohey & Co., Inc.). Costs range from: 55.00 (school-time accident plan) to $199 (tackle football accident plan).

I/We understand that Nogales unified School District No. 1 will not pay any medical expenses.
I/We will notify the school when there is a change in my/our insurance coverage.

Father's /Guardian's Signature: _____ Date: _____

Mother's /Guardian's Signature: _____ Date: _____

Student's Signature: _____ Date: _____

STUDENT HEALTH HISTORY

This 2-page form must be completed annually **by the parent/guardian** to participate in any sport.

Student's Name: _____ Date: _____

Address: _____ Phone #: _____

Name of Family Physician: _____ Phone #: _____

Sport Participation QTR 1: _____
Sport Participation QTR 2: _____
Sport Participation QTR 3: _____
Sport Participation QTR 4: _____

Has your child ever had or now has any of the following:
Please be as specific as possible with details.

Allergies	yes	no	Details:_____	Year: _____
Anemia	yes	no	Details:_____	Year: _____
Arthritis	yes	no	Details:_____	Year: _____
Asthma	yes	no	Details:_____	Year: _____
Back Pain	yes	no	Details:_____	Year: _____
Concussion	yes	no	Details:_____	Year: _____
Loss of Consciousness	yes	no	Details:_____	Year: _____
Diabetes	yes	no	Details:_____	Year: _____
Emotional Problem	yes	no	Details:_____	Year: _____
Epilepsy (seizures)	yes	no	Details:_____	Year: _____
Fainting	yes	no	Details:_____	Year: _____
Hearing Trouble	yes	no	Details:_____	Year: _____
Heart Murmur	yes	no	Details:_____	Year: _____
Hepatitis	yes	no	Details:_____	Year: _____
Hernia (rupture)	yes	no	Details:_____	Year: _____
Ankle Injury	yes	no	Details:_____	Year: _____
Elbow Injury	yes	no	Details:_____	Year: _____
Eye Injury	yes	no	Details:_____	Year: _____
Joint Pain	yes	no	Details:_____	Year: _____
Kidney Trouble	yes	no	Details:_____	Year: _____
Menstrual Cramps	yes	no	Details:_____	Year: _____
Migraines	yes	no	Details:_____	Year: _____
Mononucleosis	yes	no	Details:_____	Year: _____
Knee Injury	yes	no	Details:_____	Year: _____
Knee Surgery	yes	no	Details:_____	Year: _____
Rheumatic Fever	yes	no	Details:_____	Year: _____
Spine Injury	yes	no	Details:_____	Year: _____
Sinus Problem	yes	no	Details:_____	Year: _____
Sore Throat	yes	no	Details:_____	Year: _____
Tuberculosis	yes	no	Details:_____	Year: _____
Valley Fever	yes	no	Details:_____	Year: _____
Neck Injury	yes	no	Details:_____	Year: _____
Wrist Injury	yes	no	Details:_____	Year: _____
Knee Surgery	yes	no	Details:_____	Year: _____

STUDENT HEALTH HISTORY (continued)

OPERATIONS:

Nature: _____ Year: _____

Nature: _____ Year: _____

Nature: _____ Year: _____

FRACTURES: _____

SPRAINS/DISLOCATIONS: _____

GENERAL QUESTIONS:
Does student need to stop while running the ½ mile? Yes _____ No _____
Reason:_____

If student has had prolonged absences from school, state reason why and when these occurred: _____

List medicines which student is allergic to: _____

Medicine student is currently taking: _____

If under doctor's treatment, state why and give doctor's name: _____

Sport(s) from which student is to be excluded: _____

Reason: _____

Date of last: Tetanus Booster: _____ Chest X-Ray: _____

If emergency service involving medical action or treatment is required and neither the parent nor guardian can be contacted, I hereby consent for the above named student to be given medical care by the doctor selected by the school.

_____ _____
Parent/Guardian Signature Date

Concussion Information and Waiver Athlete Concussion Awareness

To be read and signed by student-athlete and parent

Parent/Athlete Concussion Information

A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by a bump, blow or jolt to the head or body that causes the head and brain to move rapidly back and forth. All concussions are serious. Many concussions occur without loss of consciousness. Recognition and proper response to concussions when they first occur can help further injury or even death.

WHAT ARE THE SIGNS AND SYMPTOMS OF A CONCUSSION?

Signs and symptoms of a concussion can show up right after the injury or may appear days or weeks after the injury. If an athlete reports a bump, blow, or jolt to the head or body, he/she may experience some of the symptoms identified below:

Signs Observed by the Coaching Staff:

- ✓ Appears dazed or stunned
- ✓ Is confused about position or assignment Forgets an instruction
- ✓ Is unsure of game score or opponent Moves clumsily
- ✓ Answers questions slowly
- ✓ Loses consciousness (even briefly)
- ✓ Shows mood, behavior, or personality changes
- ✓ Cannot recall events prior to hit or fall
- ✓ Cannot recall events after hit or fall

Symptoms Reported by Athletes:

- ✓ Headaches or "pressure" in the head
- ✓ Nausea or vomiting
- ✓ Balance problems or dizziness
- ✓ Double or blurry vision
- ✓ Sensitivity to noise
- ✓ Feeling sluggish, hazy, foggy, or groggy
- ✓ Concentration or memory problems
- ✓ Confusion. Just not "feeling right" or "feeling down

CONCUSSION DANGER SIGNS

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. An athlete should receive immediate medical attention if after a bump, blow or jolt to the head or body they exhibit any of the following danger signs:

- ✓ One pupil larger than the other
- ✓ Is drowsy or cannot be awakened
- ✓ A headache that gets worse or slurred speech
- ✓ Weakness, numbness or decreased coordination

- ✓ Convulsions, seizures or unusual behavior
- ✓ Cannot recognize people or places
- ✓ Becomes increasingly confused or agitated
- ✓ Loses consciousness for any amount of time

WHY SHOULD AN ATHLETE REPORT HIS/HER SYMPTOMS?

If an athlete has a concussion, his/her brain needs time to heal. While an athlete's brain is healing, he/she is much more likely to have another concussion. Repeat concussions can increase the time it takes to recover. In rare cases, repeat concussions in young athletes can result in brain swelling or permanent damage to their brain. It can even be fatal.

WHAT SHOULD YOU DO IF YOU THINK YOUR CHILD HAS A CONCUSSION?

If you suspect that your child has a concussion, remove him/her from play and seek medical attention. Do not allow the coach (or yourself) to judge the severity of the injury. ***Keep the student out of play until a medical professional says he/she is symptom free and is able to return to play***. Here are some other pointers:

- ✓ Rest is the key to help an athlete recover.
- ✓ Exercising or activities that involve a lot of concentration (studying, computers, and video games) may cause concussion symptoms to reappear or worsen.
- ✓ After a concussion, returning to sports and school is a gradual process that should be carefully managed and monitored by a health care professional. Children and teens with a concussion should NEVER return to sports or recreation activities (e.g., PE class, sports practices/games, and recess play) on the same day the injury occurred.

I (we), hereby acknowledge having received education about the signs, symptoms and risks of sport related concussion as provided in the information above. I also acknowledge my responsibility to report to my coaches, parent(s) / guardian(s) any signs or symptoms of a concussion.

_____	_____	_____
Printed name of student-athlete	**Date**	**Sport(s):**
_____	_____	_____
Signature of student-athlete	**Date**	**Sport(s):**

I, the parent / guardian of the student-athlete(s) named above, hereby acknowledge having received education about the signs, symptoms and risks of sport related concussion as provided in the information above.

_____	_____
Signature of parent / guardian	**Date**

ANNUAL HEATH UPDATE

(To be completed annually **by a licensed physician** in the United States)

Dear Medical Care Provider and Parent:

"Yes" answers on any of the questions from the Student Health History indicate that this child has possibly had an event that may pose a hazard to his/her sports participation. We ask the medical care provider to review all "yes" responses as well as additional medical concerns identified on the previous two pages to determine whether the child is fit for sports participation at our school.

Thank you.

Student's Last Name	First Name	MI	Sex	Grade	Date of Birth
_____			_____	_____	_____

Upon review of the "yes" responses and additional medical concerns identified, NEW RESTRICTIONS should be imposed. These restrictions / limitations are:

_____

_____

_____ _____

Medical Care Provider's Signature MD/DO/NP/PA-C Date

Upon review of the "yes" responses and additional medical concerns identified, NO NEW RESTRICTIONS should be imposed.

_____ _____

Medical Care Provider's Signature MD/DO/NP/PA-C Date

PHYSICAL EXAMINATION SUMMARY

(To be completed annually **by a licensed physician** in the United States)

Student's Last Name	First Name	MI	Sex	Grade	Date of Birth
_____	_____	_____	_____	_____	_____

Per ALA Bylaws: Article 15, Student Eligibility Rules, Section 15.7, Paragraph 15.7.3, Subparagraph 15.7.2.2

The following is to be completed and signed by the examining medical care provider: (MD/DO/NP/PA-C)

Height: _____ Weight: _____ Eyes: R20/_____ L20/ _____

Ears: R_____ L_____ Nose/Throat: _____ Teeth/Dentures: _____ Heart: _____

Lungs: _____ BP (right arm/sitting): _____ Abdomen: _____ Hernia: _____

Pulse at Rest:_____ Spine/Neck:_____ Shoulders/Elbow/Hands: _____

Hip/Knee: _____ Ankle/Feet: _____ Genitalia: _____ Lymphatic: ____

Laboratory:
Urinalysis (dip stick) _____ Albumin: _____ Sugar: _____ Blood: _____

Other Lab Tests (only if specifically indicated or required):

Urinalysis: sp.gr: _____ Rest: _____ Tuberculin Test: _____ Pos: _____
Neg: _____

I certify that I have, on this date, examined the above named student and I have found no medical reason to disqualify him/her from participating in all supervised athletics and physical education with the EXCEPTION OF: _____

Name of Medical Care Provider (type/print) MD/DO/NP/PA-C

Signature of Examining Medical Care Provider Date