PARTICIPANT FORMS

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CONCUSSION INFORMATION PARENT AND STUDENT VERIFICATION

In accordance with AS 14.30.142, the School District requires that each athlete, and each minor athlete's parent/guardian, receive written information on the nature and risks of concussions each year. Students may not participate in school athletic activities unless the student and parent/guardian of a student who is under 18 years of age have signed a current verification that they have received the information provided by the District. Parents will be provided with a pamphlet provided by the Alaska School Activities Association entitled "A Parent's Guide to Concussions in Sports." Students will be provided with a fact sheet produced by the U.S. Dept. of Health and Human Services Centers for Disease Control and Prevention entitled "Head's Up: Concussion in High School Sports – A Fact Sheet for Athletes." Students who are 18 years of age or older will also be provided with the Parent's Guide.

Parents and Students should review this information, discuss it at home, and direct any questions to the student's coach, school principal or athletic activities director.

For more information go to: **http://asaa.org/resources/sports-medicine/**

Student Acknowledgement (required for all athletes)

I acknowledge that I have received a copy of "Head's Up: Concussion in High School Sports – A Fact Sheet for Athletes" and understand its contents.

Student Signature

Print Name

Date

_____/_____/_____

Parent/Guardian/Eligible Student Acknowledgement (Parent signature required for all students under 18 years of age; student signature required for students age 18 or older)

I acknowledge that I have received a copy of "A Parent's Guide to Concussions in Sports" and understand its contents.

Parent/Guardian/Eligible Student Signature

Print Name

Date

_____/_____/_____

Play for Keeps
ALASKA SCHOOL ACTIVITIES ASSOCIATION

Student, Parent/Guardian Acknowledgement Form

Please read the following statements, sign below and return to your school's

- I have participated in ASAA's "Play for Keeps" orientation which includes watching the orientation video.
- I understand the terms of the Tobacco, Alcohol and Controlled Substances Policy as explained during the presentation, including the following penalties for violations.
    - First Offense - 5 days suspension and must complete the first offence educational component
    - Second Offense - 45 days suspension and additional components
    - Third Offense - 6 months suspension and additional components
    - Fourth Offense - 1 year suspension and additional components

  Additional components can be found within the Play for Keeps - Tobacco, Alcohol and Controlled Substances (TAD) Policy.
- I further understand that it is solely the school's responsibility to determine if a violation has occurred and that the school's decision may not be appealed to ASAA.
- I further understand that schools are required to report each violation to ASAA and to maintain strict confidentiality as specified in the policy. More specific wording of the confidentiality statement is found in the policy which is available from the school or at www.asaa.org.
- I further understand that students and parents/guardian must participate in the orientation and sign this form annually as part of the student's eligibility process.
- I further understand that a copy of this signed form must be returned to the school before the student is permitted to participate in interscholastic activities.
- I further understand that schools shall keep a copy of the signed forms on file.
- After participating in the "Play for Keeps" orientation and having the opportunity to review and understand ASAA' s Tobacco, Alcohol and Controlled Substances Policy, the violations, penalties and reporting requirements, I agree (both student and parent/legal guardian) to be bound by the terms of the policy.

Printed Name of Student	**Student Signature**	**Date**
		_____/_____/_____

Printed Name of Parent/Guardian	**Parent/Guardian Signature**	**Date**
		_____/_____/_____

Sport or Activity	**School**

SUDDEN CARDIAC ARREST

PARENT & STUDENT INFORMATION SHEET

Sudden Cardiac Arrest (SCA) is the leading cause of death in student athletes. It happens suddenly and often without warning. SCA is where the heart stops beating suddenly. An individual will stop breathing and collapse, lying motionless or appearing to have a seizure.

CAUSES OF SCA INCLUDE:

- Structural heart defects (hypertrophic cardiomyopathy, Marfan syndrome etc.)
- Electrical Heart Defects (long QT syndrome, Wolff-Parkinson White Syndrome, etc.)
- Blow to the chest (Commotio Cordis)

RISK FACTORS FOR SCA INCLUDE:

- Fainting or seizures during or immediately following exercise
- Chests pains during exercise
- Unexplained shortness of breath, long time to catch breath
- Dizziness
- Unusually rapid heart rate
- Extreme fatigue, always tired and lack of energy
- Unexplained sudden death of a direct family member under the age of 50

If you have any of the risk factors consult your healthcare provider

TO INCREASE THE CHANCES OF SURVIVING SCA THERE SHOULD BE:

1. An Emergency Action Plan in place for every practice and event
2. Someone immediately calling 911
3. An Automated External Defibrillator (AED) immediately accessible
4. Cardiopulmonary Resuscitation (CPR) hands only started immediately

I have reviewed and understand the symptoms and warning signs of SCA

TO BE COMPLETED BY THE STUDENT AND HIS/HER PARENT OR GUARDIAN.

_____

Student Name (please print)

_____ _____

Student Signature **Date**

_____ _____

Parent or Guardian Signature **Date**

PARENT/GUARDIAN CONSENT FOR STUDENT TRAVEL AND PARTICIPATION

STUDENT

Student Last Name | **Student First Name** | **MI** | **Date of birth** | **Grade**

_____/_____/_____

Phone | **School**

To comply with the requirements of the Alaska Department of Education and Early Development regulation 4 AAC 06.115, indicate what gender the student was assigned at birth:

☐ Male ☐ Female

PARENT/GUARDIAN

Parent/Guardian Last Name | **Parent/Guardian First Name** | **MI**

Address | **City** | **Zipcode**

Email

CONSENT FOR PARTICIPATION AND PHOTO/VIDEO RELEASE

I hereby give my consent for the above named student to engage in ASAA or school district approved interscholastic activities as a representative of his/her school. I give my consent for the the above named student to accompany the group as a member on out-of-town trips.

I hereby grant to the ASAA the right to record, as it relates to participation in an ASAA activity, the image and/or voice and use the artwork and/or written work of myself and/or my child on videotape, on film, on photographs, in digital media and in any other form of electronic or print medium and to edit such recording at their discretion. I further grant the right to use, and to allow others to use, my and/or my child's image, voice, artwork, and/or written work on the internet, television, in brochures, and in any other electronic or print medium.

I hereby release the ASAA and their successors using my and/or my child's image and/or voice, artwork, and/or written work pursuant to this media release from any and all claims, damages, liabilities, costs and expenses which I and/or my child now have or may hereafter have by reason of any use thereof. I understand this release means that I and/or my child are to receive no compensation with respect to the use described above. I also hereby relinquish any right that I or my child may have to examine or approve any completed media product that may be used by the ASAA.

Parent/Guardian name (please print) | **Parent/Guardian signature** | **Date**

_____/_____/_____

PARENT/GUARDIAN CONSENT FOR STUDENT TRAVEL AND PARTICIPATION

Continuation

INSURANCE COVERAGE

I understand that the Alaska State Board of Education and Alaska School Activities Association (ASAA) do not carry medical or liability insurance covering students traveling for interscholastic activities. I HEREBY WAIVE ON BEHALF OF MYSELF AND THE ABOVE NAMED STUDENT ANY LIABILITY RESPONSIBILITIES OF THE BOARD OF EDUCATION OR ASAA, EITHER ORGANIZATIONALLY OR FOR ANY OF ITS OFFICERS, AGENTS OR EMPLOYEES, FOR INJURIES OR DAMAGES SUSTAINED IN THE INTERSCHOLASTIC PROGRAM. I also understand that medical or liability insurance is my responsibility.

HEALTH CONDITIONS

For the wellfare of the above named student, it would helpful to know if they have any of the following medical conditions (not required):

- ☐ Allergies (explain):_____
- ☐ Asthma
- ☐ Cardiac Condition
- ☐ Diabetes
- ☐ Prosthetic
- ☐ Seizure Disorder
- ☐ Other (explain):_____
- ☐ None

CONSENT FOR EMERGENCY MEDICAL TREATMENT

In consideration of the above named student's opportunity to participate in interscholastic activities, I hereby give my consent to medical examination, emergency medical treatment, hospitalization or other medical treatment as may be necessary for the welfare of the above named student, by a physician, nurse practitioner, PA, athletic trainer, cerified community health aid, and/or hospital in the event of illness or injury during all periods of time in which the student is away from his or her legal residence as a member of an interscholastic activity group. I further hereby waive on behalf of myself and the above named student, any liability of the school district or ASAA, its officers, agents or employees, arising out of such medical treatment.

Coverage is provided as follows:
- ☐ Native Health Service
- ☐ Military
- ☐ Private Insurance Carrier
- ☐ I assume financial responsibilities for injuries.

Name of Insurer:_____ Policy Number: _____

Phone of Insurer:_____

Parent/Guardian name (please print)

Parent/Guardian signature

Date _____/_____/_____

Parent/Guardian phone number

Parent/Guardian emergency phone number

Personal Physicians Name

Personal Physicians phone number

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

TO: **Medical Provider**

I hereby authorize you to release copies of all medical information in your possession, whether paper or electronic, relating to student health review/exams of the student identified below to the school or school district in which the student is enrolled and to appropriate health care providers.

Name of school or school district

This release authorizes disclosure of this information to the school for purposes of the school's determining the fitness of the student to participate in strenuous physical activities, including but not limited to competitive athletic events.

I understand that the medical information disclosed by the medical provider to the school may be further disclosed by the school to the school's administrators, athletic director and coaches of any interscholastic activities in which I seek to participate.

I understand that once the information is disclosed, it may be re-disclosed by the recipient and federal law may not protect the information.

I understand that I may revoke this authorization in writing at any time, except to the extent action has been taken in reliance on this authorization.

I certify that the signatures on this release are voluntary.

Photocopies of this release shall have the same authority as the original. This release will expire one year from the date of signatures on this form, unless revoked earlier by me in writing.

Date of signature

_____/_____/_____

Signature of student

Printed or typed name of student

Student's social security number (optional)

Date of birth

_____/_____/_____

CONSENT OF PARENT

I am the parent or legal guardian of the above student, and authorize the foregoing release of medical information to the student's school/school district and to appropriate health care providers.

Date of signature

_____/_____/_____

Signature of parent / legal guardian

Printed or typed name of parent / legal guardian

STUDENT HEALTH REVIEW/EXAM

To be completed by parent or guardian.

Student Last Name | **Student First Name** | **MI** | **Date of birth** | **Grade**

_____/_____/_____

Address | **City** | **Zipcode**

Phone | **Emergency Phone** | **Date of last physical exam**

_____/_____/_____

Are your immunizations up to ☐ Yes ☐ No | **Last tetanus shot** _____/_____/____ | **Last measles shot** _____/_____/___ | **Last TB skin test** _____/_____/___

		YES	NO
1.	Have you ever been hospitalized?	☐	☐
2.	Have you been diagnosed with COVID-19?	☐	☐
3.	Have you ever had surgery?	☐	☐
4.	Are you presently taking any medications, pills or supplements?	☐	☐
5.	Have you ever passed out during or after exercise?	☐	☐
6.	Have you ever been dizzy during or after exercise?	☐	☐
7.	Have you ever had chest pain during or after exercise?	☐	☐
8.	Do you tire more quickly than your friends during exercise?	☐	☐
9.	Have you ever had high blood pressure?	☐	☐
10.	Have you ever been told that you have a heart murmur?	☐	☐
11.	Have you ever had racing of your heart or skipped beats?	☐	☐
12.	Has anyone in your family died of heart problems or sudden death before age 50?	☐	☐
13.	Do you have any skin problems *(itching, rashes, acne)*?	☐	☐
14.	Have you ever had a head injury?	☐	☐
15.	Have you ever had a concussion? If yes, how many_____	☐	☐
16.	Have you ever been knocked out or unconscious?	☐	☐
17.	Do you suffer from migraines?	☐	☐
18.	Have you ever had a seizure?	☐	☐
19.	Have you ever had a stinger, burner or pinched nerve?	☐	☐
20.	Have you ever had heat or muscle cramps?	☐	☐
21.	Have you ever been dizzy or passed out in the heat?	☐	☐
22.	Do you have trouble breathing or do you cough during or after activity?	☐	☐
23.	Do you use any medical assistant devices *(insulin pump, prosthetic, implanted device, etc.)*?	☐	☐
24.	Have you ever had problems with your eyes or vision?	☐	☐
25.	Do you wear glasses or contacts or protective eye wear?	☐	☐
26.	Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries in any of the following bones or joints?	☐	☐
	___Head ___Shoulder ___Thigh ___Neck ___Elbow ___Knee ___Chest ___Forearm ___Shin/calf ___Back ___Wrist ___Ankle ___Hip ___Hand		
27.	Are you Diabetic?	☐	☐
28.	Are you Asthmatic?	☐	☐
29.	Have you had any medical problem or injury since your last evaluation?	☐	☐
30.	Do you have any allergies *(medicine, bees or other stinging insects)*??	☐	☐
	List all allergies: _____		
31.	Have you ever had other medical problems *(infectious mononucleosis, etc.)*?	☐	☐
32.	When was your first menstrual period? _____		
	When was your last menstrual period? _____		
	What was the longest time between your periods last year? _____		
33.	Explain all "yes" answers: _____		

I hereby state that, to the best of my knowledge, my answers to the above questions are correct and give consent for my student to be examined.

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

STUDENT HEALTH REVIEW/EXAM

To be completed by physician, physician assistant, advanced nurse practitioner or doctor of chiropractic

This form to be sent to the school (do not send to ASAA)

Student Last Name	Student First Name	MI	Date of birth	Grade
			_____/_____/_____	

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. If conditions arise after the athlete had been cleared for participation, the physician may rescind the clearance until the problem is resolve and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of M.D., D.O. P.A., ANP or DC (circle)	Signature	Date
		_____/_____/_____

Address	Phone