Edgewood Independent School District
Kennedy High School/ Brentwood/ Wrenn
Memorial High School/Gus Garcia
San Antonio, TX

March 20, 2013

Dear Student/ Parent/ Guardian,

It is that time of year to start preparing for the upcoming 2013-2014 athletic season. Edgewood ISD is offering students the opportunity to get a free sport physical again this year. All students who are entering their first or third year of participation in athletics will be required to get a sport physical. However, ALL students, including those in their second and fourth years of participation are required to complete the emergency data forms, UIL permit form, UIL acknowledgement of rules form, UIL steroid agreement, medical history form, concussion acknowledgement form, and asthma form (If student has asthma) on a yearly basis. This means that all students are required to complete paperwork in order to be eligible for sports in 2013-14.

The sports physicals for Memorial High School are scheduled for Thursday, April 11, 2013 from 3pm-5pm. Kennedy High School boys & Brentwood Middle School will be Tuesday April 9th, 2013 from 7:45am-11am. Wrenn Middle School boys will be from 7:45am-11am on Tuesday, April 16th. Kennedy High School girls, Wrenn Middle School girls, & Brentwood remaining will be on Thursday, April 18th from 3pm-6pm. Gus Garcia Middle School will be on Tuesday, April 30th, 2013 from 3pm-6pm. Any student wishing to participate in athletic events will be eligible to obtain a free physical at this time. Any student who needs a physical in order to participate in school sports that does NOT attend these physical dates will have to go on their own to a qualified professional (chiropractor, nurse practitioner, or medical doctor) to get a physical. Paperwork will be distributed to all athletes beginning on March 26th, 2013. Any student who doesn't have athletics and is interested can pick up a physical packet from their athletic trainer. Students who intend to receive a free physical will be required to fill out paperwork and turn it into their head coach at least one day before the scheduled physical date.

Note: It is IMPERATIVE that all paperwork is filled out entirely, signed by the student and parent BEFORE a physical can be administered. The student will not be able to proceed to the physical unless filled out correctly. On the day of the physicals, there will be a check in station and staff members will review the physical packets. The doctors will not be able to give a physical to any student, unless paperwork is properly completed. Also, please see flyer for instructions on what to wear for the physical. If you have any questions, please don't hesitate to contact us. Thank you for your cooperation and support.

Sincerely,

Latissa Eisenberg
Kennedy High School
Office: 210-444-3151
Email: latissa.eisenberg@eisd.net

Monica Garza
Memorial High School
Office: 210-444-8345
Email: monica.garza@eisd.net

EISD Athletic Department

2013 – 2014 Student Athlete Personal Data & Emergency Information

Important: All information must be COMPLETED by the parent or legal guardian & the Athletic Permit Form signed (see back) BEFORE the student athlete may participate in PRACTICE GAME/SCRIMMAGE - OFF SEASON.

In case of an injury or emergency, we will make every effort to contact you through the information you provide below. In case we have to act in your behalf in securing medical care, we need the following information on file to give the medical care provider.

PLEASE PRINT. USE DARK BLUE OR BLACK INK. NO OTHER COLOR INK or PENCIL WILL BE ACCEPTED

Student Information: ____
Last Name First Name Middle Name Nick Name

Social Security # : _____ - _____ - _____ Date of Birth : _____ - _____ - _____ (Month Day Year) Age : _______ MALE / FEMALE (Circle)

Address: ______________________ Phone:__________ Grade:__________ (13-14 School Year) __________ (School for 13-14)

Female Legal Guardian Information

Name : ______________________ Social Security #: _____ - _____ - _____

Relation to student? (circle one) Mother, Step-Mother, Grandmother, Aunt, Sister, or Other (Specify) __________

Home Address: ______________ Zip Code: _______ Home Phone:__________

Employer/Company: ______________ Employer's Phone: __________

Employer's Address: ______________ Pager or Cell Phone: __________

Male Legal Guardian Information

Name: ______________________ Social Security #: _____ - _____ - _____

Relation to student? (Circle One) Father, Step-Father, Grandfather, Uncle, Brother, or Other (Specify) __________

Home Address: ______________ Zip Code: _______ Home Phone: __________

Employer/Company: ______________ Employer's Phone: __________

Employer's Address ______________ Pager or Cell Phone: __________

Emergency Contact Information

Emergency Contact # 1: Name:______________ Phone: _______ Relationship: __________

Emergency Contact # 1: Name:______________ Phone: _______ Relationship: __________

Medical Alert: Athlete's medical conditions/allergies: ______________________

Personal & School Insurance Information ***(All 4 questions must be answered "yes" or "no".)***

Personal insurance is to be applied initially concerning ALL medical bills. The school's athletic insurance will be applied after the athlete has applied his or her personal insurance or has no personal insurance. Please list any and all medical insurance that covers your son/daughter. Do not list auto or life insurance. (The school's athletic insurance only covers accidents/injuries sustained in the **supervised** athletic program. Such activities as "open gym' are **not** covered.) NOTE: CARELINK is NOT insurance.

Any remaining balance after insurance has paid will be the responsibility of the parent/legal guardian.

A copy of insurance card/Medicaid identification is required.

1. **Does the athlete have Medicaid Coverage?** (Circle) Yes / No (If yes, please complete the following:)
   Case Number: ______________ **Student's Medicaid ID Number**: ______________
   Name of Medicaid Plan: ______________ Required Hospitals: ______________
   Name of Physician: ______________ Physician's Phone: ______________
2. **Does this student have "CHIPS" insurance?** (Circle) Yes / No (If yes, please complete the following:)
   Name of "CHIPS" Program:______________ Student ID#:__________
   Physician or Medical Group:______________ Physician's Phone #:__________
   Required or preferred hospital:______________
3. **Is this student carried as a dependent on a parent's insurance?** (Circle) Yes / No (If yes, complete the following:)
   Name of Insurance Co.: ______________ HMO?_______ PPO?_______
   Insurance Co. Phone #: ______________ Group #: __________ Policy #: __________
   Policyholder's Name: ______________ Policyholder's Social Security #: _____-_____-_____
   Primary Care Physician Referral Needed? (Circle) Yes / No Required Hospitals/Emergency Rooms: __________
   Primary Care Physician's Name: ______________ Primary Care Physician's Phone #: __________
   Is this personal insurance noted above the only insurance that covers your son/daughter? (Circle) Yes / No
4. **Does the athlete have Military Coverage?** (Circle) Yes / No (If yes, complete the following:)
   ____ **CHAMPUS** _____ **TriCare** ______ **Military Privileges** **Required Facilities** ______________
   Sponsor's Name: ______________ Sponsor's Social Security #: _____ - _____ - _____

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EISD Athletic Department
2013 – 2014 Parent / Legal Guardian Athletic Permit for UIL Sports

PLEASE PRINT! USE DARK BLUE OR BACK INK. NO OTHER COLOR INK OR PENCIL WILL BE ACCEPTED.

Print: Athlete's last name ______ **First name** ______ **Date of Birth** ______ **School/Grade for 2013-2014** ______

PARENT / LEGAL GUARDIAN: PLEASE READ CAREFULLY. SIGNATURE REQUIRED BELOW.

1. **I hereby give my consent** for the above student to COMPETE and TRAVEL in the following sports: (circle)
   Contact Football Baseball Basketball Cross-Country Golf Soccer Softball Tennis Volleyball Track & Field
2. **I hereby give my consent** for the above student to COMPETE in UIL approved SPORTS as stated above and TRAVEL with the coach or other representative of the school on any trips until revoked in writing by me.
3. **I DO NOT** give my consent for the student above to COMPETE or TRAVEL in the following sports:
   ______
4. **I understand** that even though protective equipment is worn by the athlete whenever needed, **the possibility of catastrophic or fatal injury remains.** Neither the UIL nor the school district assumes any responsibility in case an accident occurs.
5. **I hereby agree** to be responsible for the safe return of all athletic equipment and medical equipment issued by the school to the above named student.
6. If, in the judgement of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, **I do hereby request, authorize, and consent** to such care and treatment as may be given said student by any physician, hospital, athletic trainer, nurse or school representative, and I do hereby agree, to indemnify and save harmless the school and any school representative from any claim by any person whomsoever on account of such care and treatment of said student.
7. **I authorize** any medical provider to release any and all medical records concerning my son/daughter to the EISD Athletic Trainers. A copy of this form will be as valid as the original.
8. **I agree** to notify the EISD Athletic Trainer of any illness or condition that occurs outside of athletics during the summer or school year.
9. **It is the athlete's and parent's responsibility** to make the athletic trainer aware of any injury **occurring in the athletic program**. Notification should be made at the time of injury – or within that week – so proper medical attention is given and insurance procedures are met.
10. **Any illness or condition** which is not directly caused by an injury in athletics is the parent's /legal guardian's financial responsibility and will not be covered by the EISD athletic insurance.
11. **I hereby state** that, to the best of my knowledge, the information given on the Medical History Form is correct.

Doctor Referral Procedure:

If your son/daughter requires medical attention as a result of an athletic injury, a doctor referral or hospital / emergency room visit will be initiated by the EISD Athletic Trainer. Should your son/daughter with an athletic injury visit any doctor or hospital without initial referral from the EISD Athletic Trainer, the EISD Athletic Trainer will not file an insurance claim for medical bills regarding that athletic injury. **(Special forms are required before going to the medical facility)**

PARENT / LEGAL GUARDIAN – PLEASE READ AND SIGN THE FOLLOWING STATEMENT:

I hereby certify I fully understand and agree to the Parent / Legal Guardian Permit above. I certify that there is no other medical insurance coverage other than what is stated on the reverse side of this form that will cover my son/daughter. I understand the *Doctor Referral Procedure* (above) and *Personal & School Insurance* (on reverse side). **I understand that all balances from Medical bills not covered by insurance will be the responsibility of the parent or legal guardian.**

Printed Name of Parent / Legal Guardian ______ **Date** ______ **Signature of Parent / Legal Guardian** ______

Printed Name of Student Athlete ______ Date ______ Signature of Student Athlete ______

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PRE-PARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY - 13-14

This **MEDICAL HISTORY FORM** must be completed ***annually*** by parent (or guardian) and student in order for the student to participate in athletic activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an athletic event.

Student's Name:______________________ Sex _____ Age_____ Date of Birth ______________

Address ______________________________ Phone ______________

Grade ______________ School ______________________________

Personal Physician ______________________ Phone ______________________

In case of emergency, contact:

Name ______________ Relationship______________ Phone (H) ______________(W) ______________

Explain "Yes" answers below. (After #18) Circle questions you don't know the answers to. *Pre-participation Form on the reverse side.*

	Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?	❑	❑
2. Have you been hospitalized overnight in the past year?	❑	❑
Have you **EVER** had surgery?	❑	❑
3. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	❑	❑
4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	❑	❑
5. Have you ever passed out during or after exercise?	❑	❑
Have you ever been dizzy during or after exercise?	❑	❑
Have you ever had chest pain during or after exercise?	❑	❑
Do you get tired more quickly than your friends do during exercise?	❑	❑
Have you ever had racing of the heart or skipped heartbeats?	❑	❑
Have you had high blood pressure or high cholesterol?	❑	❑
Have you ever been told you have a heart murmur?	❑	❑
Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	❑	❑
Has any family member been diagnosed with enlarged heart, hypertrophic cardiomyopathy, long QT syndrome, Marfan's syndrome, or abnormal heart rhythm)?	❑	❑
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	❑	❑
Has a physician ever denied or restricted your participation in sports for any heart problems?	❑	❑
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	❑	❑
7. Have you ever had a head injury or concussion?	❑	❑
Have you ever been knocked out, become unconscious, or lost your memory?	❑	❑
If yes, how many times? ____ When was the last concussion?	❑	❑
How severe was each one? (Explain below)	❑	❑
Have you ever had a seizure?	❑	❑
Do you have frequent or severe headaches?	❑	❑
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	❑	❑
Have you ever had a stinger, burner, or pinched nerve?	❑	❑
8. Have you ever become ill from exercising in the heat?	❑	❑
9. Have you ever gotten unexpectedly short of breath with exercise?	❑	❑
Do you cough, wheeze, or have trouble breathing during or after activity?	❑	❑
Do you have asthma?	❑	❑
Do you have seasonal allergies that require medical treatment?	❑	❑
10. Have you had any problems with your eyes or vision?	❑	❑
11. Are you missing any paired organs?	❑	❑
12. 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 orthodontics, retainer on your teeth, hearing aid)?	❑	❑
13. Have you ever had a sprain, strain, or swelling after injury?	❑	❑
Have you broken or fractured any bones or dislocated any joints?	❑	❑
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	❑	❑

If yes, check appropriate box and explain below

❑ Head	❑ Elbow	❑ Hip
❑ Neck	❑ Forearm	❑ Thigh
❑ Back	❑ Wrist	❑ Knee
❑ Chest	❑ Hand	❑ Shin/Calf
❑ Shoulder	❑ Finger	❑ Ankle
❑ Upper Arm		❑ Foot

	Yes	No
14. Do you want to weigh more or less than you do now?	❑	❑
Do you lose weight regularly to meet weight requirements for your sport?	❑	❑
15. Do you feel stressed out?	❑	❑
16. Record the dates of your most recent immunizations (shots) for:	❑	❑

Tetanus __________ Measles __________

Hepatitis B __________ Chickenpox __________

	Yes	No
17. Are you under a doctor's care?	❑	❑

Females Only

18. When was your first menstrual period? _____

When was your most recent menstrual period? _____

How much time do you usually have from the start of one period to the start of another? _____

How many periods have you had in the last year? _____

What was the longest time between periods in the last year? _____

EXPLAIN "YES" ANSWERS HERE: ______________________________

____

____

____

____

____

It is understood that even though protective equipment is worn by the athlete, whenever needed, the possibility of an accident still remains. Neither the University Interscholastic League nor the high school assumes any responsibility in case an accident occurs.

If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student.

If, between this date and the beginning of athletic competition, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury.

To the Parent:
Circle any activity in which this student is allowed to participate.

High School: Golf, Soccer, Football, Softball, Tennis, Basketball, Track & Field, Baseball, Team Tennis, Volleyball, Cross Country

Middle School: Football, Volleyball, Soccer, Basketball, Track & Field

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Student Signature: ______________ Parent/Guardian Signature: ______________ Date: ________

NEEDS DENTAL EXAM	NEEDS VISION EXAM	NEEDS B/P RE-CK	NEEDS A.T. LETTER	NEEDS MEDICAL CLEARANCE

E.I.S.D. ATHLETIC DEPARTMENT

U.I.L. PRE-PARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAMINATION 13 – 14

***NOTE:** STUDENT/PARENT SHOULD ONLY COMPLETE INFORMATION ON TOP LINE.*

Student's Name ______________________________ Sex ___ Age ___ Date of Birth ______________

COMPLETED EXAM FORM GIVING CLEARANCE MUST BE ON FILE WITH THE ATHLETIC TRAINER BEFORE ATHLETE MAY PRACTICE – SCRIMMAGE – COMPETE IN EVENT OR PARTICIPATE IN OFF SEASON PROGRAM. It must be completed prior to junior high athletic participation and again prior to first and third years of high school athletic participation. It must be completed if there are "yes" answers to specific questions on the student's MEDICAL HISTORY FORM on the reverse side.

Height____ Weight ____ Pulse ________ BP____/______ (______/_______, ______/______)

Uncorrected Vision: R 20/___ L 20/____ Corrected Vision: R 20/___ L 20/____ Corrected with: Glasses Contacts Pupils: Equal ____ Unequal ______
Dental: WNL:_____ Cavities_____Missing Teeth _____Chipped/Broken "Crooked"_____

	NORMAL	ABNORMAL FINDINGS	Station-based exam only. INITIALS*
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in the supine position.			
Heart-Auscultation of the heart in the standing position.			
Heart-Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULAR SKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*Medical History (on reverse side) should be reviewed by medical provider.

CLEARANCE

- ❑ Cleared
- ❑ Cleared after completing evaluation/rehabilitation for: ______________________________
- ❑ Not cleared for: ______________________ Reason: ______________________

Recommendations: ____

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner, will not be accepted.

Name (print/type)______________________________ Date of Examination:______________
Address: ______________________________ Phone Number:______________
Signature: ______________________________ Circle: M.D., D.O., PA-C, R.N./FNP-C, D.C.

*Must be completed before a student participates in any practice, before, during or after school, (both in-season and out-of-season) or games/matches.

Medical History Explanation Sheet

If you answered 'yes' to any questions on the medical history form, please use this space to provide explanations for your answers. Please provide dates and specific circumstances. NOTE: If all of the questions are not answered or explanations were not provided for every 'yes' answer, the form will be considered incomplete and will not pass for sport clearance.

ACKNOWLEDGEMENT OF RULES

Attention School Authorities: This form must be signed yearly by both the student and parent/guardian and be on file at your school before the student may participate in any practice session, scrimmage, or contest. A copy of the student's medical history and physical examination form signed by a physician or medical history form signed by a parent must also be on file at your school.

Student's Name ______________________________ Date of Birth ______________

Current School ______________________________

Parent or Guardian's Permit

I hereby give my consent for the above student to compete in University Interscholastic League approved sports, and travel with the coach or other representative of the school on any trips.

It is understood that even though protective equipment is worn by the athlete whenever needed, the possibility of an accident still remains. Neither the University Interscholastic League nor the high school assumes any responsibility in case an accident occurs.

I have read and understand the University Interscholastic League rules on the reverse side of this form and agree that my son/daughter will abide by all of the University Interscholastic League rules.

The undersigned agrees to be responsible for the safe return of all athletic equipment issued by the school to the above named student.

If, in the judgement of any representatives of the school, the above student needs immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given to said student by any physician, licensed athletic trainer, nurse, hospital, or school representative; and I do hereby agree to indemnify and save harmless the school and any school representative from any claim by any person whomsoever on account of such care and treatment of said student.

I have been provided the UIL Parent Information Manual regarding health and safety issues including concussions and my responsibilities as a parent/guardian. I understand that failure to provide accurate and truthful information on UIL forms could subject the student in question to penalties determined by the UIL.

The UIL Parent Information Manual is located at www.uiltexas.org/files/athletics/manuals/parent-information-manual.pdf.

Your signature below gives authorization that is necessary for the school district, its licensed athletic trainers, coaches, associated physicians andstudent insurance personnel to share information concerning medical diagnosis and treatment for your student.

To the Parent: Check any activity in which this student is allowed to participate.

- ☐ Baseball
- ☐ Basketball
- ☐ Cross Country
- ☐ Wrestling
- ☐ Football
- ☐ Golf
- ☐ Soccer
- ☐ Softball
- ☐ Swimming & Diving
- ☐ Team Tennis
- ☐ Tennis
- ☐ Track & Field
- ☐ Volleyball

Date ______________

Signature of parent or guardian ______________________________

Street address ______________________________

City ______________ State ______________ Zip ______________

Home Phone ______________ Business Phone ______________

GENERAL INFORMATION

School coaches may not:

- Transport, register, or instruct students in grades 7-12 from their attendance zone in non-school baseball, basketball, football, soccer, softball, or volleyball camps (exception: See Section 1209 of the Constitution and Contest Rules).
- Give any instruction or schedule any practice for an individual or a team during the off-season except during the one in school day athleticperiod in baseball, basketball, football, soccer, softball, or volleyball
- Schools and school booster clubs may not provide funds, fees, or transportation for non-school activities.

GENERAL ELIGIBILITY RULES

According to UIL standards, students could be eligible to represent their school in interscholastic activities if they:

- are not 19 years of age or older on or before September 1 of the current scholastic year. (See Section 446 of the Constitution and Contest Rules for exception).
- have not graduated from high school.
- are enrolled by the sixth class day of the current school year or have been in attendance for fifteen calendar days immediately preceding a varsity contest.
- are full-time students in the participant high school they wish to represent.
- initially enrolled in the ninth grade not more than four years ago.
- are meeting academic standards required by state law.
- live with their parents inside the school district attendance zone their first year of attendance. (Parent residence applies to varsity athletic eligibility only.) When the parents do not reside inside the district attendance zone the student could be eligible if: the student has been in continuous attendance for at least one calendar year and has not enrolled at another school; no inducement is given to the student to attend the school (for example: students or their parents must pay their room and board when they do not live with a relative; students driving back into the district should pay their own transportation costs); and it is not a violation of local school or TEA policies for the student to continue attending the school. Students placed by the Texas Youth Commission are covered under Custodial Residence (see Section 442 of the Constitution and Contest Rules).
- have observed all provisions of the Awards Rule.
- have not been recruited. (Does not apply to college recruiting as permitted by rule.)
- have not violated any provision of the summer camp rule. Incoming 10-12 grade students shall not attend a baseball, basketball, football, soccer, or volleyball camp in which a seventh through twelfth grade coach from their school district attendance zone, works with, instructs, transports or registers that student in the camp. Students who will be in grades 7, 8, and 9 may attend one baseball, one basketball, one football, one soccer, one softball, and one volleyball camp in which a coach from their school district attendance zone is employed, for no more than six consecutive days each summer in each type of sports camp. Baseball, Basketball, Football, Soccer,Softball, and Volleyball camps where school personnel work with their own students may be held in May, after the last day of school, June, July and August prior to the second Monday in August. If such camps are sponsored by school district personnel, they must be heldwithin the boundaries of the school district and the superintendent or his designee shall approve the schedule of fees.
- have observed all provisions of the Athletic Amateur Rule. Students may not accept money or other valuable consideration (tangible or intangible property or service including anything that is usable, wearable, salable or consumable) for participating in any athletic sport during any part of the year. Athletes shall not receive valuable consideration for allowing their names to be used for the promotion of any product, plan or service. Students who inadvertently violate the amateur rule by accepting valuable consideration may regain athletic eligibility by returning the valuable consideration. If individuals return the valuable consideration within 30 days after they are informed of the rule violation, they regain their athletic eligibility when they return it. If they fail to return it within 30 days, they remain ineligible for one year from when they acceptedit. During the period of time from when students receive valuable consideration until they return it, they are ineligible for varsity athletic competition in the sport in which the violation occurred. Minimum penalty for participating in a contest while ineligible is forfeiture of the contest.
- did not change schools for athletic purposes.

I understand that failure to provide accurate and truthful information on UIL forms could subject the student in question to penalties determined by the UIL.

I have read the regulations cited above and agree to follow the rules.

_______________ _______________________________

Date Signature of student

EISD ATHLETIC DEPARTMENT

NON-PRESCRIPTION MEDICATION PERMISSION FORM

Please complete this form. No Pencil. Use Dark Blue or Black Ink. No other ink colors will be accepted.

Athlete's **Printed** Name	Athlete's Date of Birth	School

The E.I.S.D. Athletic Trainers keep certain non-prescription medications available for student athletes. These medications may be dispensed to the student athletes for such conditions as athletic injuries, swelling and pain associated with sports. These medications will be dispensed according to the District Team Physician's Standing Orders with your permission.

Please fill out the bottom portion of this form and return the entire form to the Athletic Trainer.

** Please list ALL medications/conditions/foods that your child is allergic to:

____

My signature below gives the E.I.S.D. Athletic Trainers my permission to give my daughter/son the following non-prescription medications – as needed and according to guidelines of the District Team Physician's Standing Orders – as indicated with "Yes" being circled.

Parent: Circle "Yes" or "No" for the following:

1) Acetaminophen (Tylenol)	Yes	No
2) Antihistamine (Benadryl)	Yes	No
3) Ibuprofen (Advil, Motrin)	Yes	No

(X) ______________________________ ______________

Parent's/Legal Guardian's *Signature* Date

Rev. April, 2012

CONCUSSION ACKNOWLEDGEMENT FORM

Name of Student ______________________________

Definition of Concussion - means a complex pathophysiological process affecting the brain caused by a traumatic physical force or impact to the head or body, which may: (A) include temporary or prolonged altered brain function resulting in physical, cognitive, or emotional symptoms or altered sleep patterns; and (B) involve loss of consciousness.

Prevention – Teach and practice safe play & proper technique.
- Follow the rules of play.
- Make sure the required protective equipment is worn for all practices and games.
- Protective equipment must fit properly and be inspected on a regular basis.

Signs and Symptoms of Concussion – The signs and symptoms of concussion may include but are not limited to: Head ache, appears to be dazed or stunned, tinnitus (ringing in the ears), fatigue, slurred speech, nausea or vomiting, dizziness, loss of balance, blurry vision, sensitive to light or noise, feel foggy or groggy, memory loss, or confusion.

Oversight - Each district shall appoint and approve a Concussion Oversight Team (COT). The COT shall include at least one physician and an athletic trainer if one is employed by the school district. Other members may include: Advanced Practice Nurse, neuropsychologist or a physician's assistant. The COT is charged with developing the Return to Play protocol based on peer reviewed scientific evidence.

Treatment of Concussion - The student-athlete shall be removed from practice or competition immediately if suspected to have sustained a concussion. Every student-athlete suspected of sustaining a concussion shall be seen by a physician before they may return to athletic participation. The treatment for concussion is cognitive rest. Students should limit external stimulation such as watching television, playing video games, sending text messages, use of computer, and bright lights. When all signs and symptoms of concussion have cleared and the student has received written clearance from a physician, the student-athlete may begin their district's Return to Play protocol as determined by the Concussion Oversight Team.

Return to Play - According to the Texas Education Code, Section 38.157:
A student removed from an interscholastic athletics practice or competition under Section 38.156 may not be permitted to practice or compete again following the force or impact believed to have caused the concussion until:
(1) the student has been evaluated, using established medical protocols based on peer-reviewed scientific evidence, by a treating physician chosen by the student or the student 's parent or guardian or another person with legal authority to make medical decisions for the student;
(2) the student has successfully completed each requirement of the return-to-play protocol established under Section 38.153 necessary for the student to return to play;
(3) the treating physician has provided a written statement indicating that, in the physician 's professional judgment, it is safe for the student to return to play; and
(4) the student and the student 's parent or guardian or another person with legal authority to make medical decisions for the student:
(A) have acknowledged that the student has completed the requirements of the return-to-play protocol necessary for the student to return to play;
(B) have provided the treating physician 's written statement under Subdivision (3) to the person responsible for compliance with the return-to-play protocol under Subsection (c) and the person who has supervisory responsibilities under Subsection (c); and
(C) have signed a consent form indicating that the person signing:
(i) has been informed concerning and consents to the student participating in returning to play in accordance with the return-to-play protocol;
(ii) understands the risks associated with the student returning to play and will comply with any ongoing requirements in the return-to-play protocol;
(iii) consents to the disclosure to appropriate persons, consistent with the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191), of the treating physician 's written statement under Subdivision (3) and, if any, the return-to-play recommendations of the treating physician; and
(iv) understands the immunity provisions under Section 38.159.

______________________________ ______________________________
Parent or Guardian Signature *Date*

______________________________ ______________________________
Student Signature *Date*

University Interscholastic League

Parent and Student Agreement/Acknowledgement Form
Anabolic Steroid Use and Random Steroid Testing

- Texas state law prohibits possessing, dispensing, delivering or administering a steroid in a manner not allowed by state law.
- Texas state law also provides that body building, muscle enhancement or the increase in muscle bulk or strength through the use of a steroid by a person who is in good health is not a valid medical purpose.
- Texas state law requires that only a licensed practitioner with prescriptive authority may prescribe a steroid for a person.
- Any violation of state law concerning steroids is a criminal offense punishable by confinement in jail or imprisonment in the Texas Department of Criminal Justice.

STUDENT ACKNOWLEDGEMENT AND AGREEMENT

As a prerequisite to participation in UIL athletic activities, I agree that I will not use anabolic steroids as defined in the UIL Anabolic Steroid Testing Program Protocol. I have read this form and understand that I may be asked to submit to testing for the presence of anabolic steroids in my body, and I do hereby agree to submit to such testing and analysis by a certified laboratory. I further understand and agree that the results of the steroid testing may be provided to certain individuals in my high school as specified in the UIL Anabolic Steroid Testing Program Protocol which is available on the UIL website at www.uil.utexas.edu. I understand and agree that the results of steroid testing will be held confidential to the extent required by law. I understand that failure to provide accurate and truthful information could subject me to penalties as determined by UIL.

Student Name (Print): ____ Grade (9-12) _______

Student Signature: ______________________________ Date: ___________

PARENT/GUARDIAN CERTIFICATION AND ACKNOWLEDGEMENT

As a prerequisite to participation by my student in UIL athletic activities, I certify and acknowledge that I have read this form and understand that my student must refrain from anabolic steroid use and may be asked to submit to testing for the presence of anabolic steroids in his/her body. I do hereby agree to submit my child to such testing and analysis by a certified laboratory. I further understand and agree that the results of the steroid testing may be provided to certain individuals in my student's high school as specified in the UIL Anabolic Steroid Testing Program Protocol which is available on the UIL website at www.uil.utexas.edu. I understand and agree that the results of steroid testing will be held confidential to the extent required by law. I understand that failure to provide accurate and truthful information could subject my student to penalties as determined by UIL.

Name (Print): ____

Signature: ______________________________ Date: ___________

Relationship to student: __________________________________

Name:______________________________

Date of Birth:____________

School:______________________________

Grade:____________

ASTHMA MEDICINE PLAN

You can use the colors of a traffic light to help learn about your asthma medicines.

1. ***GREEN*** means ***GO***. Use your everyday preventive medicines.
2. ***YELLOW*** means ***CAUTION***. Use quick-relief medicine.
3. ***RED*** means ***DANGER***! Use extra medicines and call your doctor **NOW!**

GREEN means *GO!!!!*

*** Breathing is good.**
*** No cough or wheeze.**
*** Can work and play.**

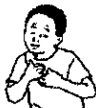
USE EVERYDAY PREVENTIVE MEDICINES.

Medicine	How much to take	Times	Circle One
			Home/School
			Home/School
			Home/School

****20 minutes before sports, use this medicine:** ____________________

YELLOW means *CAUTION!!!!*

Cough **Wheeze**



Tight Chest **Wake up at Night**

1. KEEP TAKING GREEN ZONE MEDICINES.
2. START TAKING QUICK-RELIEF MEDICINE TO KEEP AN ASTHMA ATTACK FROM GETTING BAD.

Medicine	How much to take	Times to take
Albuterol/Xopenex		now and every 4 to 6 hours

**If you DO NOT feel better in 20 to 60 minutes FOLLOW THE RED ZONE PLAN

****IF YOU CONTINUE WITH THESE SYMPTOMS FOR 12 TO 24 HOURS, CALL YOUR DOCTOR**

RED means *DANGER!!!* *GET HELP FROM A DOCTOR NOW!!!*

*** Medicine is not helping**
*** Breathing is hard and fast**
*** Nose opens wide to breathe**
*** Can't talk well**

GO TO DOCTOR'S OFFICE OR EMERGENCY ROOM!
TAKE THESE MEDICINES UNTIL YOU SEE THE DOCTOR.

Medicine	How much to take
Albuterol/Xopenex	

You may repeat this dose _________ times, 20 minutes apart.

CALL 911 (EMS) IF: Lips or fingernails are blue, or
You are struggling to breathe, or
You do not feel or look better in 20-30 minutes

Physician recommendations for Air Quality Health Alert Days: (Check one)

□ Exercise as tolerated □ No vigorous outdoor activity □ Other ______________________________

Physician recommendations for medication self-administration: (Check one)

□ I have instructed ______________________________ (student's name) in the proper way to use his/her medications. It is my professional opinion that he/she should be allowed to carry and self-administer the above medications while on school property or at school-related events

□ It is my professional opinion that ______________________________ (student's name) should NOT be allowed to carry and self-administer any of his/her asthma medication(s) while on school property or at school related events.

Printed Name of Health Care Provider	Signature of Health Care Provider	Phone Number	Date

I, ______________________________, agree with the recommendations of my child's physician as noted above and give permission for my child to receive the above medication(s) as directed. I also give permission for my child to be photographed for identification purposes and for my child's physician to share written or verbal information with the school nurse for the duration of this school year.

Signature of parent/guardian	Date

Home Telephone	Work Telephone	Cell Phone

ADAPTED FROM: The Global Initiative for Asthma (NIH Publication No.96-3659C. Dec. 1995) and Christus Santa Rosa Children's Hospital and El Centro del Barrio, San Antonio

White Copy: Patient Yellow Copy: Patient or School Pink Copy: Physician

Edgewood ISD
Athletic/Physical Education
and
Health Services/Wellness Department

Medication Protocols

1. Students, Parents, and/or Guardians acknowledge, understand, and agree if a student who participates in athletics is diagnosed with an illness warranting medication, an injury, a medical procedure (dental inclusive), and/or has side effects from said illness, injury or medical procedure (dental inclusive), after the Pre-participation Physical Evaluation, that student and/or parent/guardian is to notify the Nurse and the Coach within 3 days of diagnosis. That student must provide supporting documentation from the physician's office. _____________ _____________ (initial parent/guardian and student)

2. Students, Parents, and/or Guardians acknowledge, understand, and agree that Coaches will not accept medications from a parent/guardian. Coaches will direct parents/guardians to give any medication directly to the school nurse. The school nurse will verify the medication information, log in the medication information, deliver the medication to the coach, and provide training on recognition of signs and symptoms, medication administration, and documentation. The Coach's receipt of medication will be documented. _____________ _____________ (initial parent/guardian and student)

3. Students, Parents, and/or Guardians acknowledge, understand, and agree that the coach will keep all student medications stored securely in an easily accessible location. Under no circumstances should a student be allowed access to unsupervised medications. Students who have submitted the required paperwork from their parents/guardians and physician and who have been cleared by the school nurse may self-carry and administer their prescription asthma inhaler, Epi-pen, and or diabetes testing supplies and medication. The school nurse will inform the coaches about students who meet these requirements. _____________ _____________ (initial parent/guardian and student)

4. Students, Parents, and/or Guardians acknowledge, understand, and agree that a student, authorized to carry their prescription medication, are responsible for bringing asthma or anaphylaxis medication on field trips, local and out of town games. Each Coach must ensure those students that carry asthma or anaphylaxis medications have them prior to participating in any event. If a student fails to bring their asthma or anaphylaxis medication, that student may not participate in the event, whether local or out of town, unless a parent/guardian brings the asthma or anaphylaxis medication. If a student fails to bring said medication, and there is an out of town game/event, that student may not ride on the bus for said game/event with teammates. That student must be sent home unless the parent/guardian can bring their asthma or anaphylaxis medication ***prior to departure time***.
_____________ _____________ (initial parent/guardian and student)

5. Students, Parents, and/or Guardians acknowledge, understand, and agree only full-time certified and authorized EISD faculty may administer medications. _____________ _____________ (initial parent/guardian and student)

6. Students, Parents, and/or Guardians acknowledge, understand, and agree under no circumstance will any unauthorized medication be administered. _____________ _____________ (initial parent/guardian and student)

7. Students, Parents, and/or Guardians acknowledge, understand, and agree that Coaches will return all medications to the school nurse at the end of the athletic season and/or after the last competition of the school year. The school nurse will contact parents/guardians regarding the pick-up/disposal procedure of medications. Medications are <u>never</u> to be given directly to students. ____________ ____________ (initial parent/guardian and student)

8. Students, Parents, and/or Guardians acknowledge, understand, and agree that a Coach must follow the same protocols with every student, regardless of familial relationship, unless Coach is the parent/guardian of student; wherein, the Coach can administer medication to his/her own child. ____________ ____________ (initial parent/guardian and student)

9. Students, Parents, and/or Guardians acknowledge, understand, and agree if Legal or local policy conflicts with any of these protocols located herein, Texas Legal Policies will prevail followed by Edgewood ISD local policies. ____________ ____________ (initial parent/guardian and student)

*By signing this document you are agreeing to adhere to the protocols herein to help aid the safety and security of students.

*This document must be fully executed prior to any student participating in any event/sport.

______________________________ ______________
Printed Name of Parent/Guardian Date

______________________________ ______________
Parent/Guardian Signature Date

______________________________ ______________
Printed Name of Student Date

______________________________ ______________
Student's Signature Date

Send copies to: Athletic Director
Coach
HR Director
Nurse
Trainer

Edgewood ISD
Athletic/Physical Education

and

Health Services/Wellness Department

PROCEDURES FOR STUDENT ATHLETES WHO REQUIRE MEDICATION

To provide for the health and safety of student athletes, the following procedures must be followed when a student requires an inhaler, insulin, or an emergency medication (Glucagon, Epi-Pen, Diastat or any other) during after school practices or athletic events:

A current Medication Administration Request, Asthma Action Plan, Emergency Care Plan, Seizure Plan or Diabetes Management and Treatment Plan (DMTP) must be completed by the prescribing physician and on file in the school nurse's office. All medication must be in a currently prescribed pharmacy labeled bottled and clearly labeled with the student's name; name of medication, dose, and frequency of administration. Inhalers, insulin, and emergency medications for students shall be securely stored in the school nurse's office.

All information will be verified and the school nurse will deliver the medication to the coach and provide any required training in symptom recognition, administration and documentation. Parents/guardians of student athletes **must** provide a second inhaler, insulin, or emergency medication for the coach. It is the responsibility of the coach to keep all student medication stored in an easily accessible location. The coach will follow the physician's direction, EISD protocols for medication administration, and immediately contact parents in the event of a medical emergency during practices or sporting events.

At the end of the athletic season and/or after the last competition of the school year, medications will be returned to the school nurse and may be picked up by a parent/guardian. Medications **will not** be sent home with students.

Student's Name	Student #	Grade
Parent/Guardian's Signature	Contact #	Date
Coach's Signature	Ext #	Date
School Nurse Signature	Ext#	Date
Trainer's Signature	Ext#	Date

Send copies to: **Athletic Director**
Coach
HR Director
Nurse
Trainer