

Memorial High School

'2012 'EVeZg dg`



What: Sports Physicals



When: Saturday, May 26, 2012 8am-12pm

Where: Athletic Orthopedic Knee Center:
9180 Katy Freeway Houston TX 77055

Who: Anyone needing a sports physical!

Cost: \$25

Donate a piece of useable sports equipment and receive \$5 off

***No appointment required**

*Proceeds go to the Athletic Orthopedic Research Foundation

Supporting our community and athletic programs for over 25years!

* Students will receive a free shirt when receiving a physical

**ATHLETIC
ORTHOPEDICS &
KNEE CENTER**

FOOT & ANKLE | HAND | PAIN | SHOULDER | SPINE

rock climbing
rowing
surfing
billiards
skateboarding
judo
athletics
ice hockey
tennis
wrestling
rugby
physical activity
basketball
track and field
competition
snowboarding
rally
cycling
hockey
soccer
baseball
swimming
pool
fencing
polo
football
snooker
bowls

For more information please visit web site at www.aokc.net

Or contact Amanda Gillam, Athletic Training Coordinator 713-984-1400 ext 129 email: agillam@aokc.net

PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

REVISED 1-6-09

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: (print) _____ 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 in the box below. Circle questions you don't know the answers to. Any Yes answer to questions 1, 2, 3, 4, 5, or 6 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physician assistant, chiropractor, or nurse practitioner is required before any participation in UIL practices, games or matches**

	Yes	No		Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you ever gotten unexpectedly short of breath with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been hospitalized overnight in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	14. 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 orthotics, retainer on your teeth, hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever had a sprain, strain, or swelling after injury?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have you broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, check appropriate box and explain below.		
Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip
Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh
Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome or other ion channelopathy (Brugada syndrome, etc), Marfan's syndrome, or abnormal heart rhythm?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Knee
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Shin/Calf
Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger	<input type="checkbox"/> Ankle
4. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Foot	
Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you want to weigh more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how many _____ When was the last _____			Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
times? _____ concussion?			17. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
How severe was each one? (Explain below)			18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	Females Only		
Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	19. When was your first menstrual period? _____		
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	<input type="checkbox"/>	<input type="checkbox"/>	When was your most recent menstrual period? _____		
Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	How much time do you usually have from the start of one period to the start of another? _____		
5. Are you missing any paired organs?	<input type="checkbox"/>	<input type="checkbox"/>	How many periods have you had in the last year? _____		
6. Are you under a doctor's care?	<input type="checkbox"/>	<input type="checkbox"/>	What was the longest time between periods in the last year? _____		
7. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	An individual answering in the affirmative to any question relating to a possible cardiovascular health issue (question three above), as identified on the form, should be restricted from further participation until the individual is examined and cleared by a physician, physician assistant, chiropractor, or nurse practitioner.		
8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>	**EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary):		
9. Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
11. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
12. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>			

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 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, athletic 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.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide truthful responses could subject the student in question to penalties determined by the UIL

Student Signature: _____ Parent/Guardian Signature: _____ Date: _____

THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE OR CONTEST BEFORE, DURING OR AFTER SCHOOL.

For School Use Only:

This Medical History Form was reviewed by: Printed Name _____ Date _____ Signature _____

PREPARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAMINATION

Student's Name _____ Sex _____ Age _____ Date of Birth _____

Height _____ Weight _____ % Body fat (optional) _____ Pulse _____ BP _____/_____/_____ (_____/_____, ____/_____)
brachial blood pressure while sitting

Vision R 20/____ L 20/____ Corrected: Y N Pupils: Equal Unequal

As a minimum requirement, this **Physical Examination Form** 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. *** Local district policy may require an annual physical exam.**

NORMAL

ABNORMAL FINDINGS

INITIALS*

	NORMAL	ABNORMAL FINDINGS	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			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			

MUSCULOSKELETAL

Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*station-based examination only

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: _____

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.

SPRING BRANCH INDEPENDENT SCHOOL DISTRICT

District Athletic-U.I.L. Accident Insurance Plan

The Spring Branch Independent School District has purchased a limited benefit insurance policy that covers all student athletes while participating in, practicing, or traveling for athletic-U.I.L. competition. The District is asking each individual who participates in the athletic-U.I.L. insurance plan to pay a portion of the cost. For the 2011-2012 school year this cost is only \$25.00.

The athletic insurance is not a 24 hour accident insurance.

(If you need additional accident coverage for your student, a limited benefit plan may be purchased through a school student insurance plan (see the brochure you received from your child's school) that will provide limited benefits for the student when he/she is not participating in athletic-U.I.L. events.)

The following information concerns the District's Athletic-U.I.L. coverage:

1. The cost of the policy to the student is only **\$25.00**. Make checks payable to **S.B.I.S.D.**
2. This policy covers the student/athlete only during regular practice, off season practice, games during their season and when involved in an activity sanctioned by the U.I.L.
3. If you have other accident insurance for the student/athlete this policy becomes a secondary excess coverage policy and will be coordinated with any personal coverage that you may have. It will become the primary coverage if there is no other personal coverage available.

The Athletic/U.I.L. competition insurance is a Limited Benefit Plan. It will not pay 100% of the bills.

(A copy of the policy benefits can be obtained by calling the Central Athletic Office at 713-251-1207.

As an additional feature the policy also offers a "Network" of providers (physicians, X-rays, etc.) that will take most benefits on full assignment with little or no cost to you. *(Contact the head trainer at each high school or The Brokerage Store at 1-800-366-4810 for more information on the "Network".*

4. Any bills not paid by your personal carrier or the athletic-U.I.L. policy will be the responsibility of the parents/guardians. **Parents/Guardians are responsible for filing any claims and any subsequent bills.**
5. If you have other insurance coverage, you **must** file with your personal insurance carrier first. If you are insured by an HMO/PPO, you must use the HMO/PPO facilities/doctors as specified by your insurance plan.
6. Except in an emergency, injuries should be reported to the campus athletic trainer or coach and a claim form should be obtained **before going to the doctor.**
7. Claim forms are available from the campus athletic trainer, campus athletic coordinator, or from the office of the District Athletic Office 713-251-1207.
8. A claim form will **not** be accepted by the insurance company if **Part A** is not filled out completely by the school trainer or the coach who witnessed the accident. Please read all instructions carefully.
9. **Please keep this information for your records.**

SPRING BRANCH INDEPENDENT SCHOOL DISTRICT

District Athletic-U.I.L. Accident Insurance Plan

Student Name: (Please Print) - _____
(last) (first)

School: (Please Print) - _____

I have read the information presented on the District Athletic-UIL Accident Insurance on the “S-02 Information” page. I agree to participate in the District’s Athletic-UIL accident insurance plan. I agree to pay \$25.00 to join this coverage. I understand this is a limited benefit insurance policy that covers all student athletes while participating in, practicing, or traveling for athletic-UIL competition. I understand Parents/Guardians are responsible for filing any claims and paying any subsequent bills not paid by the insurance company. See Information page.

If you wish to not participate in the insurance program, please contact your coach or trainer to obtain a “Refusal of Insurance” form to sign and return.

(Acceptance)

**** A. Signature of Parent/Guardian _____ Date _____

PARENT PERMISSION AND 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 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 page 2 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 judgment 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, 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 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.

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

- To the Parent:** Baseball Football Softball Tennis Wrestling
- Check any activity in which this** Basketball Golf Swimming/Diving Track & Field
- student is allowed to participate** Cross Country Soccer Team Tennis Volleyball

Date _____

Signature of parent or guardian _____

Street Address _____

City/State/Zip _____

Home area code and telephone _____ Business telephone _____

The student's signature is required on page 2 of this form.

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 (exceptions: school coaches may hold one 6-day camp in their school district for incoming 7th, 8th and 9th grade students).
- Give any instruction or schedule any practice for an individual or a team during the off-season except during the one in school day athletic period 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 are 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 504 handicapped 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 day students in a participant high school.
- initially enrolled in the ninth grade not more than four calendar 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 represented a college in a contest.
- 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 held within 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 allow 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 accepted it. 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 they violation occurred. Minimum penalty for participating in a contest while ineligible is forfeiture of the contest.
- did not change schools for athletic purposes.
- **I have been provided the UIL Parent Information Manual regarding health and safety issues and my responsibilities as a parent/guardian. I understand that failure to provide accurate and truthful information as 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



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 texas.org. 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 texas.org. 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: _____



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

Student's Name _____ Birthdate: ____/____/____ SS#: ____/____/____
Print (Last),(First)(Middle (Mo) (Day) (Yr)

Sex: (circle one) M F GradeLevel: _____ Sport _____

Home address: _____ Zip: _____

Home phone w/area code: _____

Father's name: _____ Business/Cell phone: _____

Mother's name _____ Business/Cell phone: _____

List another person to be notified in case of emergency if parents are not available:

1. _____ Relationship: _____

Home phone: _____ Business/Cell phone: _____

Special Medical Conditions to be noted (i.e. Allergies) _____

(I)(We), the undersigned, parent(s) do hereby authorize any official of Spring Branch Independent School District to act as designee for the above named minor to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is prescribed by, and is to be rendered under the special supervision of, any licensed physician/or surgeon, whether such diagnosis or treatment is rendered at the office of said physician/or surgeon or at a hospital or elsewhere.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being rendered and is given to provide authority and power on the part of our aforesaid designee to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician/surgeon may, for reasons he/she deems appropriate, prescribe.

(I)(We), hereby authorize any hospital which has provided treatment to the above named minor to surrender physical custody of such minor to (my)(our) named designee(s) upon completion of treatment. This authorization is given for designee(s) for those times that (I)(We) cannot be reached by telephone at home or work at the numbers listed below.

This authorization is not to be construed as releasing any physician or surgeon from any requirement that he or she adhere to the lawful standard of care in attending to the named minor and is not to be construed as creating any financial responsibility on the part of the Spring Branch Independent School District or the named officials thereof for any health care provided the named minor. PARENTS ARE RESPONSIBLE FOR PAYMENT.

This authorization shall become effective as of _____ 20____ and remain effective until _____ 20____

Signature of Parent or Legal Guardian: _____

Insurance Information is required if Insurance Waiver is Signed.

Provide a photocopy of your insurance I.D. card.

Insurance Company Name: _____

Policy Number: _____ Group Number: _____

Name on Policy: _____

For Office Use Only: SBISD Ins.? Yes No