

PARADISE VALLEY UNIFIED SCHOOL DISTRICT NO. 69

ATHLETIC INFORMATION

CHECK ALL THAT APPLY

<input type="checkbox"/> BADMINTON	<input type="checkbox"/> SPIRITLINE	<input type="checkbox"/> BASEBALL
<input type="checkbox"/> X COUNTRY	<input type="checkbox"/> VOLLEYBALL	<input type="checkbox"/> SOFTBALL
<input type="checkbox"/> FOOTBALL	<input type="checkbox"/> BASKETBALL	<input type="checkbox"/> TENNIS
<input type="checkbox"/> GOLF	<input type="checkbox"/> SOCCER	<input type="checkbox"/> TRACK
<input type="checkbox"/> SWIM / DIVE	<input type="checkbox"/> WRESTLING	



STUDENT ID # _____

OFFICE USE ONLY	
<input type="checkbox"/> Emergency Card	<input type="checkbox"/> Clearance Issued
<input type="checkbox"/> I C Video	<input type="checkbox"/> Physical

STUDENT _____ BIRTHDAY: _____ SEX: _____ GRADE: _____

HOME ADDRESS: _____ CITY: _____ ZIP: _____

PARENT(S) NAME: _____ HOME PHONE: _____ WORK PHONE: _____

If not living with parents, name of Guardian _____ Relationship? _____

School or schools attended last year: _____

IF PARENT OR GUARDIAN CANNOT BE CONTACTED IN AN EMERGENCY, PLEASE CONTACT:

NAME: _____ HOME PHONE: _____ WORK PHONE: _____

PHYSICIAN: _____ PHYSICIAN'S PHONE: _____

PREFERRED HOSPITAL: _____ ALLERGIES: _____

I hereby give consent for coaches, trainers, or a team physician to use their judgment in securing medical aid in emergencies.

INSURANCE

It is recommended that each student athlete have medical insurance coverage. THE PARADISE VALLEY UNIFIED SCHOOL DISTRICT DOES NOT PROVIDE HEALTH INSURANCE FOR STUDENT ATHLETES. Parents are highly encouraged to obtain insurance as they are responsible for medical bills incurred as a result of participation in athletics. Parents must provide insurance information to assist coaches, trainers, other athletic staff, and medical people in the event an athlete may require medical assistance as a result of injury.

I have purchased school insurance: Yes No I have my own insurance: Yes No

Insurance Co.: _____ Policy No.: _____

PARENT CONSENT SPORTS INJURY VIDEO

In order to participate in District organized athletics, each student together with their parent or guardian **must view** the online Parent Consent Sports Injury Video prior to participating in their first District organized athletic sport. A link to this video can be found at <http://cmweb.pvschools.net/stusrvpvsdathleticsweb/>. BY MY SIGNATURE BELOW, I CONFIRM THAT MY STUDENT ATHLETE AND I HAVE VIEWED THE ONLINE VIDEO, AND UNDERSTAND THE RISKS INVOLVED IN PARTICIPATION IN DISTRICT ATHLETICS.

PARENT/GUARDIAN SIGNATURE _____ DATE: _____

STUDENT ATHLETE DRUG TESTING CONSENT

I/WE HAVE RECEIVED, READ, AND UNDERSTAND A COPY OF THE Paradise Valley Unified School District Parent and Athlete Informed Consent and Random Drug Testing Handbook. I will allow my son/daughter to participate in this drug program while participating as a high-school athlete in the Paradise Valley Unified School District and hereby voluntarily agree to be subject to the terms of the Prevention Program. I accept the method of obtaining urine samples, testing and analysis of such specimens and all other aspects of the program. I agree to cooperate in furnishing urine specimens that may be required from time to time.

I further agree and consent to the disclosure of the sampling, testing and results as provided in the program. This consent is given pursuant to all state and federal privacy statutes and constitutional and common law privacy provisions and is a waiver of right to nondisclosure of such test records and results, only to the extent of the disclosure authorized in the program.

PERMISSION TO TRANSPORT

I/We give the District permission for our son/daughter to be transported by District vehicles to away games and off-site practices as required.

EQUIPMENT CODE

It is the athlete's responsibility to care for and return all equipment issued by the high school. I/We understand and agree that all equipment issued to our son/daughter is the property of the high school and must be returned in reasonable condition. Items lost, stolen or abused must be replaced and the Athletic Department reimbursed for the cost of the equipment.

CODE OF CONDUCT/HANDBOOK

I have read and understand the information in the Informed Consent Handbook, including the PVUSD statement of understanding and the high school Code of Conduct, and attest to the fulfillment of all rules and requirements for athletes, as outlined in the handbook.

RELEASE OF NAME AND/OR IMAGE

Except as indicated by our signature directly below, I/we give the District permission for my/our son/daughter to be photographed while participating in District sporting events, and for such photographs to be used in various media publications and formats, including but not limited to web pages, newspaper articles, district publications, and/or district site newsletters. I/We also agree to allow such photographs to be captioned from time to time with my/our son's/daughter's complete name.

By my/our signature here, I/we serve notice that we do not want my/our son's/daughter's name and/or image used by the District in any format or publication, and I/we hereby refuse to grant the permissions described directly above. _____

ACKNOWLEDGEMENT

I/we have read, understand, and will abide by the statements listed on both sides of this form.

PARENT/GUARDIAN SIGNATURE _____ DATE: _____

STUDENT SIGNATURE: _____ DATE: _____

STUDENT HEALTH HISTORY - STUDENT NAME _____

TO BE COMPLETED BY PARENT PRIOR TO PHYSICAL: DOES YOUR CHILD NOW HAVE, OR HAS YOUR CHILD EVER HAD:

Yes	No		Yes	No		Yes	No		Yes	No	
___	___	ALLERGIES	___	___	ANEMIA	___	___	ARTHRITIS	___	___	ASTHMA
___	___	CONCUSSION	___	___	DIABETES	___	___	EPILEPSY (SEIZURES)	___	___	FAINING
___	___	HEART TROUBLE	___	___	HEART DYSFUNCTION	___	___	HEPATITIS	___	___	KIDNEY TROUBLE
___	___	MIGRAINE HEADACHES	___	___	MONONUCLEOSIS	___	___	RHEUMATIC FEVER	___	___	VALLEY FEVER

IS STUDENT NOW UNDER DR. CARE? _____ IF YES, WHY? _____

FAMILY PHYSICIAN: _____ PHONE: _____

MEDICATIONS NOW TAKING: _____

ALLERGIES, INCLUDING MEDICATIONS: _____

PAST SURGERIES: _____

DATES: _____

PAST FRACTURES: _____

DATES: _____

INFORMED CONSENT TO PARTICIPATE:

I/we give our permission for the above athlete to participate in organized interscholastic athletics, realizing that such activity involves the potential for injury which is inherent in all sports. I/we acknowledge that even with the best coaching, use of the most advanced protective equipment, availability of a certified athletic trainer and strict observance of rules, injuries are still a possibility. On rare occasions, the injuries can be so severe as to result in total disability, paralysis, quadriplegia, or even death. I/we acknowledge that I/we have read and understand this warning.

TO BE COMPLETED BY PHYSICIAN

HEIGHT _____	HEART _____	TEETH _____
WEIGHT _____	LUNGS _____	PULSE _____
VISION: _____	ABDOMEN _____	B/P _____
R 20/ _____	GENITALIA _____	HEARING: R _____ L _____
L 20/ _____	LYMPHATICS _____	SPINE _____
WEARS: _____	HERNIA _____	NECK _____
GLASSES _____	OTHER LAB TESTS: _____	JOINTS _____
CONTACTS _____	_____	REFLEX: _____
URINALYSIS: _____	_____	UPPER _____
ALBUMIN _____	_____	LOWER _____
SUGAR _____	SKIN _____	FAMILY HISTORY: _____
BLOOD _____	NOSE/THROAT _____	DIABETES () YES () NO
		HEART DISEASE () YES () NO
		CANCER () YES () NO

DATE OF LAST TETANUS / DIPHTHERIA: _____

I CERTIFY THAT I HAVE, ON THIS DATE, EXAMINED THE ABOVE NAMED STUDENT AND FOUND NO MEDICAL REASONS TO DISQUALIFY HIM / HER FROM PARTICIPATING IN ALL SUPERVISED ATHLETICS EXCEPT:

OPTIONAL ORTHOPEDIC EXAMINATION

NECK	WNL	ABNL	KNEES	WNL	ABNL	ANKLE	WNL	ABNL
IMPINGEMENT SIGN	_____	_____	VALGUS	_____	_____	INVERSION STRESS	_____	_____
COMPRESSION TEST	_____	_____	VARUS	_____	_____	EVERSION STRESS	_____	_____
STRENGTH	_____	_____	LACHMAN	_____	_____	TALAR TILT	_____	_____
BACK	_____	_____	PIVOT SHIFT	_____	_____	ANTERIOR DRAWER	_____	_____
SHOULDER	_____	_____	A/P DRAWER	_____	_____	FEET	_____	_____
ELBOW	_____	_____	HAMSTRINGS	_____	_____			
HIPS	_____	_____	RECOMMENDATIONS	_____	_____			

THE ATHLETE **MAY** OR **MAY NOT** COMPETE IN ATHLETICS BASED ON THE DATA GATHERED FROM THIS EXAMINATION.

Physician Name (please print) _____

Physician Signature _____ Date _____

Address _____ Phone _____