KIMBERLY HIGH SCHOOL ATHLETIC INFORMATION CARD

THIS CARD MUST BE FILED EVERY YEAR <u>BEFORE</u> PARTICIPATION CAN BEGIN IN ANY ATHLETIC PROGRAM.

1. Examination taken ***after April 1*** is good for the following **<u>TWO SCHOOL YEARS.</u>**
2. Examination taken ***before April 1*** is good for the remainder of that **<u>SCHOOL YEAR</u>** and the following **<u>SCHOOL YEAR</u>**.

NAME _____ **GRADE** _____ **BIRTHDATE** _____
Last First M. MM/DD/YYYY

SPORT PARTICIPATING IN: _____ _____ _____
FALL **WINTER** **SPRING**

DATE of Student's Most Recent Medical Sports Physical Examination: _____
(If unsure, check with the Athletic Office for date of last card on file.)

1. I hereby give my permission for the above-named student to practice and compete and represent the school in WIAA approved sports.
2. I also attest to the fact that the above-named student has had no injury or illness serious enough to warrant a medical evaluation prior to participating this school year.
3. Pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder (collectively known as "HIPAA"), I authorize health care providers of the student named above, including Prevea Health/Hospital Sisters Health System medical personnel, emergency medical personnel and other similarly trained professionals to disclose/exchange essential medical information regarding the health condition, injury, treatment, and progress of this student to appropriate school district personnel such as but not limited to: Principal, Athletic Director, Athletic Trainer, Team Physician, Team Coach, Administrative Assistant to the Athletic Director and/or other professional health care providers, for purposes of health condition, injury, treatment, emergency care and injury record-keeping.
I understand that information used or disclosed on this authorization may possibly be re-disclosed by the recipient, and/or no longer be protected by Federal privacy standards. I understand that I have a right to know what information was disclosed to the above individuals. I understand that if I agree to sign this authorization, I will be provided a copy of it at my request. I understand that I am under no obligation to sign this form. Treatment, enrollment, or eligibility for benefits may not be based upon my decision to sign this authorization. - I understand that I may revoke this authorization. A description of how to revoke that authorization and any exceptions are included in the Notice of Privacy Practices. This notice is available through our facility website or at the patient registration desk. I understand that this authorization will remain in effect until I chose to revoke it.
4. It is recommended that information regarding your child's allergies and prescribed medication be made available.

PARENT: If there is any question that this student may not be qualified for athletic competition without, at least, a partial re-evaluation, contact your medical advisor before signing this card

_____ _____
PARENT/GUARDIAN SIGNATURE **DATE**

EMERGENCY INFORMATION

PARENT NAME _____
LAST FIRST HOME PHONE NUMBER ALTERNATE PHONE NUMBER

HOME ADDRESS _____ CITY _____ ZIP _____

PHYSICIAN _____ ADDRESS _____ PHONE _____

INSURANCE COMPANY _____ POLICY OR GROUP NO. _____

ALERGIES OR ALLERGIC REACTIONS _____

KNOWN SIGNIFICANT MEDICAL CONDITIONS _____

IN CASE OF EMERGENCY, ATTEMPT TO CONTACT A PARENT AT HOME OR AT WORK. IF WE CANNOT BE REACHED, ATTEMPT TO CONTACT THE ALTERNATE LISTED BELOW:

ALTERNATE NAME _____ PHONE _____ RELATIONSHIP _____

PERMISSION IS HEREBY GRANTED TO THE ATTENDING PHYSICIAN TO PROCEED WITH ANY MEDICAL TREATMENT. I UNDERSTAND THAT AN ATTEMPT WILL BE MADE BY THE ATTENDING PHYSICIAN TO CONTACT ME IN THE MOST EXPEDITIOUS WAY POSSIBLE. PERMISSION IS ALSO GRANTED TO THE ATHLETIC TRAINER TO PROVIDE THE NEEDED EMERGENCY TREATMENT TO THE ATHLETE PRIOR TO HIS/HER ADMISSION TO THE MEDICAL FACILITIES.

_____ _____
PARENT/GUARDIAN SIGNATURE **DATE**

<u>KHS TRAVEL RELEASE FORM</u>

Some practice and contest facilities are located off the Kimberly High School Campus. Parental permission is necessary for your student athlete's transportation. This is to certify that _____ is allowed to (please check ***<u>only one</u>***):

1. _____ Drive ***only*** themselves
2. _____ Drive themselves; drive other students; ride with other students.

_____ _____
PARENT/GUARDIAN SIGNATURE **DATE**

KIMBERLY AREA SCHOOL DISTRICT
Kimberly High School
Co-Curricular Code of Conduct Receipt and
Authorization for Random Suspicionless Drug Testing

This form must be completed and returned to the athletic office *prior* to participation in any co-curricular activity.
TO READ THE KHS CO-CURRICULAR CODE HANDBOOK, PLEASE VISIT THE KASD WEBSITE OR STOP IN THE ATHLETIC OFFICE FOR A COPY.

Student Section

I have read and understand the provisions of the Co-Curricular Code of Conduct. I have also received a copy of the WIAA Rules of Eligibility. If I do not understand any of the rules, I will ask for clarification.

As a student, I understand that my participation in co-curricular activities is a privilege and, therefore, agree to be bound by the Kimberly High School Co-Curricular Code of Conduct. I agree to participate in random suspicionless drug testing and give permission for testing and the release to the district concerning the results of said testing in the event I am randomly selected. I understand this agreement is binding through my graduation from high school.

Student Name: (please print clearly)_____

Student Signature: _____

Parent Section

I have read and understand the provisions of the Co-Curricular Code of Conduct. I have also received a copy of the WIAA Rules of Eligibility. If I do not understand any of the rules, I will ask for clarification.

As a parent, I understand that my son or daughter's participation in co-curricular activities is a privilege and, therefore, agree that they are to be bound by the Kimberly High School Co-Curricular Code of Conduct. I give my permission for my son or daughter to participate in random suspicionless drug testing and give permission for testing and the release of information to the district concerning the results of said testing in the event he or she is randomly selected. I understand this agreement is binding through my son or daughter's graduation from high school.

Parent Name: (please print clearly)_____

Parent Signature: _____

KHS & JRG CONCUSSION AND SCA AGREEMENT

I have read the Concussion and Head Injury Information. I understand what a concussion is and how it may be caused. I also understand the common signs, symptoms, and behaviors. I agree that the athlete must be removed from practice/play if a concussion is suspected and cannot return to practice/play until providing written clearance from an appropriate health care provider to his/her coach.
I agree that my child's ImPACT baseline test data may be available to persons other than the physician or clinician evaluating my child as follows:

- Your child's pre-season ImPACT Baseline test may be transferred to the organization that is providing care to your son/daughter so that it can be utilized as part of their post-concussion care.

- The physician or clinician evaluating your child may choose to make your child's test data available to other health care providers who are being consulted regarding the treatment of your child.

I have read the Sudden Cardiac Arrest Information sheet. I understand that if the athlete has any warning signs of sudden cardiac arrest, they should stop activity immediately and report the symptoms to his/her coach. Your child's health and safety are at the forefront of the student athletic experience.

Parent Signature _____ Student Signature _____