Ann Sobrato High School
401 Burnett Avenue, Morgan Hill, CA 95037 Phone: (408)201-6200 Fax: (408)465-2467

Players and Parents/Guardians:

The forms below are ALL necessary in order to participate in any athletic activity at Sobrato High School. The participation form must be completed once per academic year.
Physicals are good for ONE calendar year and MUST BE renewed before their expiration date to not interfere with eligibility. Please fill out each form ***completely*** and sign in ***all*** the appropriate spaces.
For complete eligibility a student needs:

- Completed ATHLETIC PARTICIPATION AUTHORIZATION form, including Medical Insurance information
- Physical Exam by doctor with completed within the last calendar year
- A GPA of 2.0 or higher in the previous marking period (2nd semester of 8th grade is counted)
- To participate in a scrimmage or game as a transfer student transfer paperwork must be cleared with CCS

PLEASE make sure that all necessary insurance information is filled out especially the policy number. Players are required to have valid medical coverage in order to participate in any athletic activity. If temporary coverage is needed, contact me and I have programs available for as little as $24 per year.
PLEASE make sure that ALL required signatures are on the forms, **including student's**.
Players may not participate in try-outs or practice until all forms are completed and turned in to Sue Baynes or Elisa Barragan in the ASB/Athletics Office.

Hard copies of these forms can also be found in the ASB/Athletics Office.
Thank you! Go Bulldogs!!!
If you have any questions, please feel free to contact me.

*Elisa Barragan*

…
Athletic Director
Ann Sobrato High School
408-201-6240
barragane@mhusd.org

Morgan Hill Unified School District
ATHLETIC PARTICIPATION AUTHORIZATION

Participating Sport(s)_____ Year_____

Student-Last Name First Name Middle Initial Address City Zip Grade

Parent/Guardian-Last First Name Home Phone Cell Phone Work Phone

**WARNING TO STUDENTS AND PARENTS**: By its very nature, competitive athletics may put students into situations where serious and/or permanent injuries may occur. Some forms of athletic competition include physical contact among players, the use of equipment that may be hazardous, strenuous physical exertion, or other exposures to risk that could result in serious and/or permanent injury. **By granting permission for your son/daughter to participate in inter-scholastic athletic competition, you and your student acknowledge that such a risk exists.**

**SIGNATURE OF PARENT/GUARDIAN**:_____ **DATE**:_____

**INSURANCE INFORMATION:**
State Law requires Accidental Bodily Insurance of at least $1,500 of scheduled medical and hospital benefits for all members of an athletic team. All medical, hospital, ambulance or other bills shall be charged to the parents or guardians and shall be considered the bill of such parents or guardians. **We have insurance coverage for our family, which provides at least $1,500.00 hospital benefits with:**

NAME OF COMPANY: _____ POLICY NUMBER: _____

**ANTI-STEROID POLICY**: As a condition of membership in the CIF, all schools shall adopt policies prohibiting the use and abuse of androgenic-anabolic steroids. All member schools shall have participating students and their parents/guardian/caregiver agree that the athlete will not use steroids without the written prescription of a fully licensed physician (as recognized by the AMA) to treat a medical condition (Bylaw 524). By signing below, both the student-athlete and the parents/guardian/caregiver hereby agree that the student shall not use androgenic anabolic steroids without the written prescription of a fully licensed physician (as recognized by the AMA) to treat a medical condition. We also recognize that under CIF bylaw 200.D., there could be penalties for false or fraudulent information.

**SIGNATURE OF PARENT/GUARDIAN**:_____ **DATE**:_____

**SIGNATURE OF STUDENT-ATHLETE**:_____ **DATE**:_____

**TRANSPORTATION INFORMATION**:
Morgan Hill Unified School District assumes no liability and does not provide insurance coverage for transporting students to and from athletic activities. Transportation will be arranged through buses and private vehicles. (No students are allowed to drive other students to any school activity.) Your permission is required for your son/daughter to drive themselves or ride in a private vehicle with the coach or another parent to some events during the season. All athletes will be responsible in conduct to the driver of the vehicle. It is further understood that the athletes will go and return from the event on the transportation provided, unless the coach receives a written note from the parent ahead of time. **By signing below, you give permission for your son/daughter to drive themselves or ride with the coach or other parents/guardians in a private vehicle, and you indicate your understanding that the district its employees, and volunteer drivers are released from liability.**

**SIGNATURE OF PARENT/GUARDIAN**:_____ **DATE**:_____

**PARENT PERMISSION/AUTHORIZATION**:
I authorize the above named student to participate in athletics and to be released from school as required in order to participate in the sports or activities. **In case the student becomes ill or injured, Morgan Hill Unified School District is authorized to have the student treated and I authorize the medical agency to render treatment.**

**SIGNATURE OF PARENT/GUARDIAN**:_____ **DATE**:_____

**MEDICAL AUTHORIZATION**:
I hereby certify that the above named student was examined by me on (DATE)_____ and was found physically fit to engage in athletics and/or other school activities. PLEASE NOTE: PHYSICALS ARE GOOD FOR ONE CALENDAR YEAR.

Physician's Signature Title California License Number

Has the student had any injury or physical condition that should be watched? _____ If yes, please list:

# 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 |
|---|---|---|---|
| 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. | Have you ever passed out 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 your 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, (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome or other ion channelpathy (Brugada syndrome, etc), 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? | ☐ | ☐ |
| 4. | 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? | ☐ | ☐ |
| 5. | Are you missing any paired organs? | ☐ | ☐ |
| 6. | Are you under a doctor's care? | ☐ | ☐ |
| 7. | Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler? | ☐ | ☐ |
| 8. | Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? | ☐ | ☐ |
| 9. | Have you ever been dizzy during or after exercise? | ☐ | ☐ |
| 10. | Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? | ☐ | ☐ |
| 11. | Have you ever become ill from exercising in the heat? | ☐ | ☐ |
| 12. | Have you had any problems with your eyes or vision? | ☐ | ☐ |
| 13. | Have you ever gotten unexpectedly short of breath with exercise? | ☐ | ☐ |
| | Do you have asthma? | ☐ | ☐ |
| | Do you have seasonal allergies that require medical treatment? | ☐ | ☐ |
| 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)? | ☐ | ☐ |
| 15. | 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 |
|---|---|---|---|
| 16. | Do you want to weigh more or less than you do now? | ☐ | ☐ |
| | Do you lose weight regularly to meet weight requirements for your sport? | ☐ | ☐ |
| 17. | Do you feel stressed out? | ☐ | ☐ |
| 18. | Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease? | ☐ | ☐ |

***Females Only***

19. 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? _____

**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.**

*****EXPLAIN 'YES' ANSWERS IN THE BOX BELOW*** (attach another sheet if necessary):

_____

_____

_____

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* |
|---|---|---|---|
| **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.

**Associated with _____ Sport(s):_____**
**(Student's name)**

**Business and Noninstructional Operations**

**TRANSPORTATION FOR SCHOOL RELATED TRIPS** **E 3540.2**

SCHOOL DRIVER REGISTRATION FORM

Driver (check one): [ ] Employee [ ] Parent/Guardian [ ] Volunteer

Name: _____Date of Birth: _____

**VEHICLE INFORMATION:**

Name of Owner: _____ Year: _____

Address: _____ Make: _____

_____ License Plate No.: _____

Registration Expiration: _____ Seating Capacity: _____

**INSURANCE INFORMATION:**

Insurance Company:_____ Policy No.: _____

Telephone No.: _____ Expiration Date: _____

Liability Limits of Policy: $_____

**DRIVER STATEMENT:**

I certify that I have not been convicted of reckless driving or driving under the influence of drugs or alcohol within the past five years and that the information given above is true and correct. I understand that if an accident occurs, my insurance coverage shall bear primary responsibility for any losses or claims for damages.

I certify that I will ensure that all children will be restrained using the appropriate passenger restraint systems.

Name _____ Date _____

**DRIVER INSTRUCTIONS:**

When using your vehicle to transport students on field trips or other school activity trips, please:

1. Be sure that you have registered with the district for such purposes, have a valid driver's license and current liability insurance at or above the minimum amount required by law for each occurrence.
2. Check vehicle safety: tires, brakes, lights, horn, seat belts for each rider, suspension, etc.
3. Carry only the number of passengers for which your vehicle was designed. If you have a pickup truck, carry only as many as can safely sit in the passenger compartment.
4. Require each passenger to use an appropriate passenger restraint system (child car seat or booster seat) or safety belt in accordance with law.

In case of emergency, keep the children together and call 911 and the district office (408-201-6052).

ADOPTED: September 18, 1978
REVISED: December 1, 1986
REVISED: July 14, 1997
REVISED: December 11, 2000
REVISED: May 22, 2007 (Replaces BP 3750)

MORGAN HILL UNIFIED SCHOOL DISTRICT Morgan Hill, California