

2016 CHS SOFTBALL PRE-SEASON INFORMATION

-The attached schedule (through March 5) will give you an idea about open gyms, tryouts, and the beginning practice schedule for CHS Softball this year. The Varsity and JV Game schedules are also attached!

-As of now, it does not appear that we have enough pitchers trying out to field a Varsity, JV, and JV-B team for three full schedules. (JV-B is the equivalent of 9th Grade team, or a third team for a school. In softball, this is what they call it). If this changes, and we DO FIND that we have the pitchers, we can roster players for three full teams. If it STAYS THE SAME, we will have a Varsity team of 12-13 players, and a JV team of 18-19 players. The JV team will consist of the first 12-13 players playing the 27-game JV schedule, and the last 5-6 JV players playing a LIMITED JV-B (6-10 game schedule). The JV-B games would also include SOME of the JV players that are playing the full schedule. The JV and JV-B games would be played on DIFFERENT DAYS. All the JV players will practice together under Coach Graham and Coach Mitchell.

-You must have ALL your paperwork and physicals completed by the time we start mandatory practices. This is enough of a WARNING! If you do not have the paperwork and physical on file in the CHS athletic office, you can't tryout for the teams, and you will be left off the teams. The best way to make sure this doesn't happen is to turn in the CLOVERLEAF LOCAL SCHOOLS ACTIVITIES EMERGENCY MEDICAL AUTHORIZATION FORM and the PREPARTICIPATION PHYSICAL EVALUATION FORM (this is for first-time sports players at CHS – it just needs to be done once in high school) TO COACH CARM NOW!

As for the physical, you can ask the athletic office if they have one on file for you, or what the expiration date is on your physical. You MUST have one on file that is NOT MORE THAN one year old!

-Lastly, we have a unique opportunity by FAN CLOTH to allow you an opportunity to earn a free spirit pack for the upcoming season. The spirit pack that we give each player usually contains items like practice shirts, shorts, game pants, game socks, and alternative game uniform. If we can sell 300 Fan Cloth items as a program (THAT IS A MINIMUM OF JUST 10 ITEMS PER PERSON!), we can raise enough money to cover spirit packs for everyone! There are also prizes for players that sell more in the catalog. Some items have softball on them, and others just Colts gear, and there is a variety of unique clothing in each catalog. The Sale ends on February 8th, so you would need to turn everything in to Coach Carm by that date with a goal of 10 items. Cash is fine, or checks made payable to: "CLOVERLEAF ALL SPORTS BOOSTERS/SB." (Side Note: If you sell your ten items, and for some reason, do not make a team, we will try and make something work to transfer your credit to another sport, or work something out.)

Thanks and I hope this information helps you! We look forward to the CHS Spring Softball season!

Take care!

Coach Carm

Cloverleaf HS Softball Schedule for Jan. 27-March 5 (SUBJECT TO CHANGE)

****Voluntary workouts with seniors on all non-open gym weekdays after school, but you must have a Rec Membership to participate because there are no coaches there!***

Jan. 27 – Open Gym CHS from 7:30-9 p.m.

Jan. 28 – Open Gym CHS from 7-9 p.m.

Jan. 31 – LORAIN TEAM FINAL GAMES – 9:25 and 10:50 a.m. – Warmup at 8:30 a.m.

Feb. 1 – Open Gym CHS from 7-8:30 p.m.

Feb. 2 – Open Gym CHS from 7-8:30 p.m.

Feb. 9 – Open Gym from 6-7:30 p.m.

Feb. 11 – Open Gym from 7:30-9 p.m.

Feb. 15 – Open Gym from 5-6:30 p.m.

Feb. 16 – Open Gym from 6-7:30 p.m.

Feb. 22 – MANDATORY TRYOUTS – 11/12 Graders 5-7 p.m. CHS Gym; 9/10 GRADERS 7-9 CHS Gym.

Feb. 23 – MANDATORY TRYOUTS – 11/12 Graders 5-7 p.m. CHS Gym; 9/10 GRADERS 7-9 CHS Gym.

Feb. 24 – MANDATORY TRYOUTS – 11/12 Graders 2:45-4:30 p.m. REC; 9/10 GRADERS 4:15-6 p.m. REC

Feb. 25 – MANDATORY TRYOUTS – ALL 3-5:45 p.m. REC

Feb. 26 – MANDATORY TRYOUTS – ALL 3-5:45 p.m. REC

Feb. 29 – Varsity 2:45-4:30 p.m. REC; JV & JV-B 4:15-6 p.m. REC

March 1 – Varsity 2:45-4:30 p.m. REC; JV & JV-B 4:15-6 p.m. REC

March 2 – Varsity 2:45-4:30 p.m. REC; JV & JV-B 4:15-6 p.m. REC

March 3 – Varsity 5-7 p.m. CHS Gym; JV & JV-B 7-9 CHS Gym.

March 4 – Varsity 2:45-4:30 p.m. REC; JV & JV-B 4:15-6 p.m. REC

March 5 – Varsity, JV, & JV-B 8:30-10:30 a.m. CHS Gym – PARENT/PLAYER/COACH MEETING 10:30-11 a.m. in the CHS Cafeteria!

Softball

Girls Varsity

			Place	Time
<i>5 Monday</i>	<i>3/23/16</i>	<i>Black River - Home 5 pm.</i>		
S Monday	03/14/16	Wadsworth High School	Home	5:00 PM
S Wednesday	03/16/16	Wooster High School	Home	5:00 PM
Saturday	03/26/16	OPEN DATE (Disney Wide World Games)	Away	11:00 AM
Saturday	03/26/16	OPEN DATE (Disney Wide World Games)	Away	1:00 PM
Saturday	03/26/16	OPEN DATE (Disney World Games)	Away	3:00 PM
Tuesday	03/29/16	Fairview Park High School	Home	5:00 PM
Friday	04/01/16	Wooster High School	Home	5:00 PM
Saturday	04/02/16	Buckeye High School	Away	11:00 AM
Saturday	04/02/16	Buckeye High School	Away	1:00 PM
Monday	04/04/16	Coventry High School	Away	4:15PM
Tuesday	04/05/16	Coventry High School	Home	4:15PM
Saturday	04/09/16	Firelands High School	Away	12:00 PM
Saturday	04/09/16	Firelands High School	Away	2:00 PM
Monday	04/11/16	Norton High School	Home	4:15PM
Tuesday	04/12/16	Norton High School	Away	4:15PM
Thursday	04/14/16	Woodridge High School	Away	4:15PM
Saturday	04/16/16	Norwayne High School	Home	11:00AM
Saturday	04/16/16	Norwayne High School	Home	1:00PM
Monday	04/18/16	Akron Springfield High School	Home	4:15PM
Tuesday	04/19/16	Akron Springfield High School	Away	4:15PM
Monday	04/25/16	Ravenna High School	Away	4:15PM
Tuesday	04/26/16	Ravenna High School	Home	4:15PM
Thursday	04/28/16	Woodridge High School	Home	4:15PM
Monday	05/02/16	Field High School	Home	4:15PM
Tuesday	05/03/16	Field High School	Away	4:15PM
Thursday	05/05/16	Triway High School	Away	4:30 PM
Saturday	05/07/16	Medina High School (Strike Out Cancer)	Away	9:00 AM
Monday	05/09/16	Streetsboro High School	Away	4:15PM
Tuesday	05/10/16	Streetsboro High School	Home	4:15PM

Jamie Lormeau
 Principal

Joanne Ashton
 Athletic Secretary

Athletic Director
 Craig Walkup

Softball

Girls Junior Varsity

<i>5 Monday 3/28/16</i>	<i>Black River-Home 5pm.</i>		
S Monday 03/14/16	Wadsworth High School	Home	5:00 PM
S Wednesday 03/16/16	Wooster High School	Home	5:00 PM
Friday 04/01/16	Wooster High School	Home	5:00 PM
Saturday 04/02/16	Buckeye High School	Home	11:00 AM
Saturday 04/02/16	Buckeye High School	Home	1:00 PM
Monday 04/04/16	Coventry High School	Home	4:15PM
Tuesday 04/05/16	Coventry High School	Away	4:15PM
Saturday 04/09/16	Firelands High School	Home	12:00 PM
Saturday 04/09/16	Firelands High School	Home	2:00 PM
Monday 04/11/16	Norton High School	Away	4:15PM
Tuesday 04/12/16	Norton High School	Home	4:15PM
Thursday 04/14/16	Woodridge High School	Home	4:15PM
Friday 04/15/16	Revere High School	Home	4:30 PM
Saturday 04/16/16	Norwayne High School	Away	11:00AM
Saturday 04/16/16	Norwayne High School	Away	1:00PM
Monday 04/18/16	Akron Springfield High School	Away	4:15PM
Tuesday 04/19/16	Akron Springfield High School	Home	4:15PM
Monday 04/25/16	Ravenna High School	Home	4:15PM
Tuesday 04/26/16	Ravenna High School	Away	4:15PM
Thursday 04/28/16	Woodridge High School	Away	4:15PM
Monday 05/02/16	Field High School	Away	4:15PM
Tuesday 05/03/16	Field High School	Home	4:15PM
Thursday 05/05/16	Triway High School	Home	4:30 PM
Saturday 05/07/16	Medina High School (Strike Out Cancer)	Away	9:00 AM
Monday 05/09/16	Streetsboro High School	Home	4:15PM
Tuesday 05/10/16	Streetsboro High School	Away	4:15PM
Thursday 05/12/16	Revere High School	Away	4:30 PM

Jamie Lormeau
Principal

Joanne Ashton
Athletic Secretary

Athletic Director
Craig Walkup

** Still adding two more games to max out!*

CLOVERLEAF LOCAL SCHOOLS
ACTIVITIES EMERGENCY MEDICAL AUTHORIZATION - Students 2016-2017

S-14a (Rev 6/2014)

NAME _____ PHONE _____ SCHOOL _____
(Last) (First) (Middle)

RESIDENCE ADDRESS _____
(Street/Road Number) (Post Office) (Zip)

MAILING ADDRESS _____
(Box Number) (Post Office) (Zip)

BIRTHDATE _____ Male _____ Female _____ GRADE _____ BUS#(AM) _____
(Month/Day/Year)

CITY OF BIRTH _____ HOMEROOM TEACHER _____ HR# _____

PART I OR PART II Must Be Completed

PURPOSE: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

PART I - TO GRANT CONSENT

In the event reasonable attempts to contact me at _____ (home phone) OR at work (phone # is below);

Mother's Name _____ Place of Work _____ Phone _____ Cell # _____

Father's Name _____ Place of Work _____ Phone _____ Cell # _____

STUDENT RESIDES WITH: ___Mother ___Father ___Both ___Grandparent Other _____

Or-if neither parent can be reached, I give permission for you to contact the following;

Name _____ Relationship _____ Phone _____ Cell # _____

Name _____ Relationship _____ Phone _____ Cell # _____

and/or I hereby give my consent for: (1) the administration of any treatment deemed necessary by:

Dr. _____ Phone _____ OR
(preferred physician)

Dr. _____ Phone _____ OR
(preferred dentist)

In the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to

_____ (preferred hospital) _____ (Phone)

OR TO ANY HOSPITAL REASONABLY ACCESSIBLE.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring the necessity for such surgery, are obtained prior to the performance of such surgery.

Please provide facts concerning the child's medical history including allergies, medications being taken and any physical impairments of which the school should be aware (be specific) or indicate "none known".

Parent/Guardian Signature (verifying information and consent)

Date

PART II - REFUSAL TO CONSENT - (DO NOT COMPLETE THIS PART IF PART I WAS COMPLETED)

I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to:

Signature of Parent or Guardian _____ Date _____

Address _____

THE STUDENT SHALL NOT BE CLEARED TO PARTICIPATE IN INTERSCHOLASTIC ATHLETICS UNTIL THIS FORM HAS BEEN SIGNED AND RETURNED TO THE SCHOOL



OHSAA AUTHORIZATION FORM 2015-2016

I hereby authorize the release and disclosure of the personal health information of _____ ("Student"), as described below, to _____ ("School").

The information described below may be released to the School principal or assistant principal, athletic director, coach, athletic trainer, physical education teacher, school nurse or other member of the School's administrative staff as necessary to evaluate the Student's eligibility to participate in school sponsored activities, including but not limited to interscholastic sports programs, physical education classes or other classroom activities.

Personal health information of the Student which may be released and disclosed includes records of physical examinations performed to determine the Student's eligibility to participate in school sponsored activities, including but not limited to the Pre-participation Evaluation form or other similar document required by the School prior to determining eligibility of the Student to participate in classroom or other School sponsored activities; records of the evaluation, diagnosis and treatment of injuries which the Student incurred while engaging in school sponsored activities, including but not limited to practice sessions, training and competition; and other records as necessary to determine the Student's physical fitness to participate in school sponsored activities.

The personal health information described above may be released or disclosed to the School by the Student's personal physician or physicians; a physician or other health care professional retained by the School to perform physical examinations to determine the Student's eligibility to participate in certain school sponsored activities or to provide treatment to students injured while participating in such activities, whether or not such physicians or other health care professionals are paid for their services or volunteer their time to the School; or any other EMT, hospital, physician or other health care professional who evaluates, diagnoses or treats an injury or other condition incurred by the student while participating in school sponsored activities.

I understand that the School has requested this authorization to release or disclose the personal health information described above to make certain decisions about the Student's health and ability to participate in certain school sponsored and classroom activities, and that the School is not a health care provider or health plan covered by federal HIPAA privacy regulations, and the information described below may be redisclosed and may not continue to be protected by the federal HIPAA privacy regulations. I also understand that the School is covered under the federal regulations that govern the privacy of educational records, and that the personal health information disclosed under this authorization may be protected by those regulations.

I also understand that health care providers and health plans may not condition the provision of treatment or payment on the signing of this authorization; however, the Student's participation in certain school sponsored activities may be conditioned on the signing of this authorization.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by a health care provider in reliance on this authorization, by sending a written revocation to the school principal (or designee) whose name and address appears below.

Name of Principal: _____

School Address: _____

This authorization will expire when the student is no longer enrolled as a student at the school.

NOTE: IF THE STUDENT IS UNDER 18 YEARS OF AGE, THIS AUTHORIZATION MUST BE SIGNED BY A PARENT OR LEGAL GUARDIAN TO BE VALID. IF THE STUDENT IS 18 YEARS OF AGE OR OVER, THE STUDENT MUST SIGN THIS AUTHORIZATION PERSONALLY.

Student's Signature _____ Birth date of Student, including year _____

Name of Student's personal representative, if applicable _____

I am the Student's (check one): _____ Parent _____ Legal Guardian (documentation must be provided)

Signature of Student's personal representative, if applicable _____ Date _____

A copy of this signed form has been provided to the student or his/her personal representative

PREPARTICIPATION PHYSICAL EVALUATION 2015-2016
2015-2016 Ohio High School Athletic Association Eligibility and Authorization Statement

This document is to be signed by the participant from an OHSAA member school and by the participant's parent.

I have read, understand and acknowledge receipt of the OHSAA Student Athlete Eligibility Guide which contains a summary of the eligibility rules of the Ohio High School Athletic Association. I understand that a copy of the *OHSAA Handbook* is on file with the principal and athletic administrator and that I may review it, in its entirety, if I so choose. All OHSAA bylaws and regulations from the *Handbook* are also posted on the OHSAA website at ohsaa.org.

I understand that an OHSAA member school must adhere to all rules and regulations that pertain to the interscholastic athletics programs that the school sponsors, but that local rules may be more stringent than OHSAA rules.

I understand that participation in interscholastic athletics is a privilege not a right.

Student Code of Responsibility

As a student athlete, I understand and accept the following responsibilities:

I will respect the rights and beliefs of others and will treat others with courtesy and consideration.

I will be fully responsible for my own actions and the consequences of my actions.

I will respect the property of others.

I will respect and obey the rules of my school and laws of my community, state and country.

I will show respect to those who are responsible for enforcing the rules of my school and the laws of my community, state and country.

I understand that a student whose character or conduct violates the school's Athletic Code or School Code of Responsibility is not in good standing and is ineligible for a period of time as determined by the principal.

Informed Consent – By its nature, participation in interscholastic athletics includes risk of injury and transmission of infectious disease such as HIV and Hepatitis B. Although serious injuries are not common and the risk of HIV transmission is almost nonexistent in supervised school athletic programs, it is impossible to eliminate all risk. Participants have a responsibility to help reduce that risk. Participants must obey all safety rules, report all physical and hygiene problems to their coaches, follow a proper conditioning program, and inspect their own equipment daily. **PARENTS, GUARDIANS OR STUDENTS WHO MAY NOT WISH TO ACCEPT RISK DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS FORM. STUDENTS MAY NOT PARTICIPATE IN AN OHSAA-SPONSORED SPORT WITHOUT THE STUDENT'S AND PARENT'S/GUARDIAN'S SIGNATURE.**

I understand that in the case of injury or illness requiring treatment by medical personnel and transportation to a health care facility, that a reasonable attempt will be made to contact the parent or guardian in the case of the student-athlete being a minor, but that, if necessary, the student-athlete will be treated and transported via ambulance to the nearest hospital.

I consent to medical treatment for the student following an injury or illness suffered during practice and/or a contest.

To enable the OHSAA to determine whether the herein named student is eligible to participate in interscholastic athletics in an OHSAA member school I consent to the release to the OHSAA any and all portions of school record files, beginning with seventh grade, of the herein named student, specifically including, without limiting the generality of the foregoing, birth and age records, name and residence address of parent(s) or guardian(s), residence address of the student, academic work completed, grades received and attendance data.

I consent to the OHSAA's use of the herein named student's name, likeness, and athletic-related information in reports of contests, promotional literature of the Association and other materials and releases related to interscholastic athletics.

I understand that if I drop a class, take course work through Post Secondary Enrollment Option, Credit Flexibility or other educational options, this action could affect compliance with OHSAA academic standards and my eligibility.

I understand all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly. Further I understand that if my student is removed from a practice or competition due to a suspected concussion, he or she will be unable to return to participation that day. After that day written authorization from a physician (M.D. or D.O.) or an athletic trainer working under the supervision of a physician will be required in order for the student to return to participation.

I have read and signed the Ohio Department of Health's Concussion Information Sheet and have retained a copy for myself.

By signing this we acknowledge that we have read the above information and that we consent to the herein named student's participation.

***Must Be Signed Before Physical Examination**

Student's Signature Birth date Grade in School Date

Parent's or Guardian's Signature Date



Physical

PREPARTICIPATION PHYSICAL EVALUATION 2015-2016

HISTORY FORM - Please be advised that this paper form is no longer the OHSA standard.

(Note: This form is to be filled out by the student and parent prior to seeing the medical examiner. The medical examiner should keep this form in the chart.)

Date of Exam, Name, Date of birth, Sex, Age, Grade, School, Sport(s), Address, Emergency Contact, Relationship, Phone (H), (W), (Cell), (Email)

Medicines and Allergies: Please list the prescription and over-the-counter medicines and supplements... Do you have any allergies? Yes No If yes, please identify specific allergy below.

Explain "Yes" answers below. Circle questions you don't know the answers to.

Table with columns: GENERAL QUESTIONS, HEART HEALTH QUESTIONS ABOUT YOU, HEART HEALTH QUESTIONS ABOUT YOUR FAMILY, BONE AND JOINT QUESTIONS. Includes questions 1-21.

Table with columns: BONE AND JOINT QUESTIONS - CONTINUED. Includes questions 22-25.

Table with columns: MEDICAL QUESTIONS, FEMALES ONLY. Includes questions 26-54.

Explain "yes" answers here

Blank lines for explaining "yes" answers.

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

Signature of Student, Signature of parent/guardian, Date

The student has family insurance Yes No If yes, family insurance company name and policy number:



THE ATHLETE WITH SPECIAL NEEDS - SUPPLEMENTAL HISTORY FORM

PLEASE COMPLETE ONLY IF YOUR STUDENT HAS SPECIAL NEEDS OR A DISABILITY.

Date of Exam Name Date of birth Sex Age Grade School Sport(s)

Table with 16 rows of questions regarding disabilities and medical history, including a Yes/No column.

Explain "yes" answers here

Table with 16 rows of questions regarding medical conditions, including a Yes/No column.

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Signature of Student Signature of parent/guardian Date:



PREPARTICIPATION PHYSICAL EVALUATION 2015-2016

PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

- 1. Consider additional questions on more sensitive issues.
- Do you feel stressed out or under a lot of pressure?
- Do you ever feel sad, hopeless, depressed or anxious?
- Do you feel safe at your home or residence?
- Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
- During the past 30 days, did you use chewing tobacco, snuff, or dip?
- Do you drink alcohol or use any other drugs?
- Have you ever taken anabolic steroids or used any other performance supplement?
- Have you ever taken any supplements to help you gain or lose weight or improve your performance?
- Do you wear a seat belt, use a helmet or use condoms?
- Do you consume energy drinks?
2. Consider reviewing questions on cardiovascular symptoms (questions 5-14).

Table with columns: EXAMINATION, DATE OF EXAMINATION, NORMAL, ABNORMAL FINDINGS. Rows include: Height, Weight, BP, Pulse, Vision, Corrected, MEDICAL (Appearance, Eyes/ears/nose/throat, Lymph nodes, Heart, Pulses, Lungs, Abdomen, Genitourinary, Skin, Neurologic), MUSCULOSKELETAL (Neck, Back, Shoulder/arm, Elbow/forearm, Wrist/hand/fingers, Hip/thigh, Knee, Leg/ankle, Foot/toes, Functional).

*Consider ECG, echocardiogram, or referral to cardiology for abnormal cardiac history or exam.
bConsider GU exam if in private setting. Having third part present is recommended.
cConsider cognitive or baseline neuropsychiatric testing if a history of significant concussion.

CLEARANCE FORM

Note: Authorization forms (pages 5 and 6) must be signed by both the parent/guardian and the student.

Name _____ Sex M F Age _____ Date of birth _____

Cleared for all sports without restriction
 Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

Not Cleared
 Pending further evaluation
 For any sports
 For certain sports _____
Reason _____

Recommendations _____

I have examined the above-named student and completed the pre-participation physical evaluation. The student does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. In the event that the examination is conducted en masse at the school, the school administrator shall retain a copy of the PPE. If conditions arise after the student has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician or medical examiner (print/type) _____ Date of Exam _____
Address _____ Phone _____

Signature of physician/medical examiner _____, MD, DO, D.C., P.A. or A.N.P.

EMERGENCY INFORMATION

Personal Physician _____ Phone _____

In case of Emergency, contact _____ Phone _____

Allergies _____

Other Information _____

