# *Dixie Heights High School*
# *Athlete Information Sheet*

***Student Name: _____***

***Sport:_____***

***Grade: _____*** ***Birthdate: _____***

***Email address: _____***

***Have you participated in another sport this year at Dixie? Yes No***

***If yes, what sport: _____***

***Have you transferred from another High School after entering 9th grade?***
***Yes or No If yes, what school: _____***

***In order to participate in Dixie Athletics, a student must have completed paperwork, including a copy of insurance, on file with Coach or Athletic Director prior to tryouts or practice.***

***A $40 participation fee is required for every sport that a student plays***

***If you have submitted the completed forms for a previous sport during current school year, you do not have resubmit these documents.***

***Matt Wilhoite, Athletic Director***
***Phone (859) 957 - 2818 Fax***
***(859) 341- 2531***
***matt.wilhoite@kenton.kyschools.us***
***dixieheightsathletics.com***

**Athletic Participation Form**
**Parental and Student Consent and Release**

**For High School Level (grades 9-12) participation**

The student and parents/guardian must read this statement carefully and sign where required. By signing this form, all parties agree that they have accurately completed all sections of the form and have read and agree to the terms of this form as detailed. This form **must** be completed before the student participates (hereinafter including try out for, practice and/or compete) in interscholastic athletics. This form should be kept in a secure location until the student has exhausted eligibility, graduated from high school and reached the age of 19.

## ATHLETE INFORMATION
## (This part must be completed by the student and family)

Name (Last, First, Initial) _____ _____

School Year _____ Grade _____ School _____

Home Address (Street, City, State, Zip): _____ Birth Place (County, State): _____

Gender

Date of Birth:

School Attendance History

| Grade | School Name | School Year | | Varsity Play – (Yes/No)? |
|---|---|---|---|---|
| 9 | | | | |
| 10 | | | | |
| 11 | | | | |
| 12 | | | | |

☐ Baseball ☐ Softball ☐ Archery

☐ Basketball ☐ Swimming ☐ Bass Fishing

☐ Cross Country ☐ Tennis ☐ Bowling

☐ Football ☐ Track and Field ☐ Competitive Cheer

**I am** ☐ ☐ ☐ **all you**

☐ ☐ **planning to participate in the following (check all you might try to play):**

Golf Soccer
Volleyball Wrestling
Other(s) _____

**EMERGENCY CONTACT INFORMATION**

Name (please print) | Relation to Student

Emergency Contact Address, including City, State and Zip

Daytime Phone | Cell Phone

**REQUIRED INSURANCE INFORMATION (KHSAA Bylaw 12)**

Prior to participation in practice or contests (including trying for a place on a team) in any sport or sport activity during the limitation of seasons as defined in Bylaw 23, all students are required to have medical insurance with coverage limits of at least $25,000. If this coverage is provided through the school, contact the Principal or Athletic Director regarding any potential claim. Individual schools and districts may impose additional requirements for insurance or coverage during additional periods for activities outside of Bylaw 23.

Insurance Carrier | Policy Number / ID Number | Group Number | Plan

**EMERGENCY TREATMENT INFORMATION**

The following information is recorded solely for potential hospitalization and emergency care needs and is not required to be recorded on this form. However, those failing to provide this information should be aware that this might be required by emergency treatment facilities prior to rendering service, and failure to provide could result in lack of appropriate care.

Social Security Number | Birth Date

**CONSENT INFORMATION TO PARTICIPATE, ACKNOWLEDGMENT OF RISK, ACKNOWLEDGEMENT OF ELIGIBILITY RULES, LIABILITY WAIVER AND CONSENT AND RELEASE**

As parent/legal guardian, I agree to allow my child to participate in interscholastic athletics.

The student and parent/legal guardian recognize that participation in interscholastic athletics involves some inherent risks for potentially severe injuries, including but not limited to death, serious neck, head and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to virtually all internal organs, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the muscular skeletal system, and serious injury or impairment to other aspects of the body, or effects to the general health and well being of the child. Because of these inherent risks, the student and parent/legal guardian recognize the importance of the student obeying the coaches' instructions regarding playing techniques, training and other team rules. By signing this form, the student and parent/legal guardian acknowledge that the student's participation is wholly voluntary and to having read and understood this provision.

The student and parent/legal guardian individually and on behalf of the student, hereby irrevocably, and unconditionally release, acquit, and forever discharge the KHSAA and its officers, agents, attorneys, representatives and employees (collectively, the "Releasees") from any and all losses, claims, demands, actions and causes of action, obligations, damages, and costs or expenses of any nature (including attorney's fees) that the student and/or parent/legal guardian incur or sustain to person, property or both, which arise out of, result from, occur during or are otherwise connected with the student's participation in interscholastic athletics if due to the ordinary negligence of the Releasees.

The student and parent/legal guardian acknowledge that they have read and understood the KHSAA Bylaws by distribution at http://khsaa.org/handbook/. Please be aware that a student is subject to the one-year period of ineligibility the bylaw commonly referred to as the "Transfer Rule," upon participation in any varsity contest regardless of the amount of participation or lack thereof.

The student and parent/legal guardian agree to abide by the KHSAA Bylaws and Due Process Procedure as now enacted or later amended. The student and parent/legal guardian further acknowledge that they agree to abide by the rulings of the Commissioner, Assistant Commissioner, Hearing Officer and Board of Control.

The student and parent/legal guardian acknowledge that the student must have medical insurance coverage up to a limit of $25,000 in order to be eligible to participate in interscholastic athletics.

The student and parent/legal guardian, individually and on behalf of this student, give the high school, the KHSAA and their representatives permission to release this student's demographic information (including motion picture and still photographic images) and participation statistics (including height, weight and year in school, participation history and other performance based statistics) and other information as may be requested, and agree that the student may be photographed or otherwise digitally or electronically captured during school-based competition. All of this material may be used without permission or compensation specifically related to the KHSAA and its events.

The student and parent/legal guardian consent to this student receiving a physical examination as required by the KHSAA.

The student and parent/legal guardian, individually and on behalf of this student, consent to the high school and the KHSAA and their representatives to use and disclose the necessary personally identifiable information from the student's education records including academic, financial and health care information, to third parties including school representatives, coaches, athletic trainers, medical facilities, medical staffs, KHSAA legal counsel and the media, for the purpose of receiving proper/necessary medical care and complying with the KHSAA bylaws, including making determinations regarding eligibility to participate in interscholastic athletics and any administrative or legal proceedings resulting from participation or attempted participation in interscholastic athletics, without such disclosure constituting a violation of rights under the Family Educational Rights and Privacy Act. The student and parent/legal guardian, individually and on behalf of this student, further release the high school, the KHSAA and their representatives from any and all claims arising out of the use and disclosure of said necessary personally identifiable information, and agree to release to the high school, the KHSAA, and their representatives, upon request, the detailed and completed application for financial aid.

The student and parent/legal guardian, individually and on behalf of the student, hereby acknowledge that they are aware of and will review if desired, the education materials available through the KHSAA, the Centers for Disease Control and other agencies regarding education all individuals with respect to nature and risk of concussion and head injury, including the continuance of play after concussion or head injury.

The student and parent/legal guardian, individually and on behalf of the student, hereby consent to allow the student to receive medical treatment that may be deemed advisable by the high school, the KHSAA, and their representatives in the event of injury, accident or illness while participating in interscholastic athletics, including, but not limited to, transportation of the student to a medical facility.

## STUDENT AND PARENT/GUARDIAN ACKNOWLEDGMENT OF RISK, ELIGIBILITY RULES, LIABILITY WAIVER AND CONSENT AND RELEASE AND EMERGENCY PERMISSION FORM

Students' Name (please print) _____ School _____

Student and Parent/Guardian Address including City, State and Zip _____

Signature of Student _____ Date _____

Please list above any health problems/concerns this student may have, including allergies (medications / others) and any medications presently being used

Name of Parent(s)/Guardian(s) who has/have custody of this student (please print) _____ Emergency Phone Number _____

Signature of Parent(s)/Guardian(s) who has/have custody of this student _____ Date _____

# PreparticipationPhysicalEvaluation

# HISTORYFORM

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

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

**Medicines and Allergies:** Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

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

| GENERAL QUESTIONS |
|---|
| 1. Has a doctor ever denied or restricted your partic sports for any reason? |
| 2. Do you have any ongoing medical conditions? If identify below: ☐ Asthma ☐ Anemia ☐ Di Infections _____ |
| 3. Have you ever spent the night in the hospital? |
| 4. Have you ever had surgery? |
| **HEART HEALTH QUESTIONS ABOUT YOU** |
| 5. Have you ever passed out or nearly passed out DURING or AFTER exercise? |
| 6. Have you ever had discomfort, pain, tightness, or in your chest during exercise? |
| 7. Does your heart ever race or skip beats (irregu during exercise? |
| 8. Has a doctor ever told you that you have any hea problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infectic ☐ Kawasaki disease Other: _____ |
| 9. Has a doctor ever ordered a test for your heart? ( example, ECG/EKG, echocardiogram) |
| 10. Do you get lightheaded or feel more short of brea expected during exercise? |
| 11. Have you ever had an unexplained seizure? |
| 12. Do you get more tired or short of breath more qui your friends during exercise? |
| **HEART HEALTH QUESTIONS ABOUT YOUR FAM** |
| 13. Has any family member or relative died of heart p had an unexpected or unexplained sudden death 50 (including drowning, unexplained car accident infant death syndrome)? |
| 14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmoge ventricular cardiomyopathy, long QT syndrome, s syndrome, Brugada syndrome, or catecholamine polymorphic ventricular tachycardia? |

| MEDICAL QUESTIONS | Yes | No |
|---|---|---|
| 26. Do you cough, wheeze, or have difficulty breathing during or after exercise? | | |
| 27. Have you ever used an inhaler or taken asthma medicine? | | |
| 28. Is there anyone in your family who has asthma? | | |
| 29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? | | |
| 30. Do you have groin pain or a painful bulge or hernia in the groin area? | | |
| 31. Have you had infectious mononucleosis (mono) within the last month? | | |
| 32. Do you have any rashes, pressure sores, or other skin problems? | | |
| 33. Have you had a herpes or MRSA skin infection? | | |
| 34. Have you ever had a head injury or concussion? | | |
| 35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems? | | |
| 36. Do you have a history of seizure disorder? | | |
| 37. Do you have headaches with exercise? | | |
| 38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | | |
| 39. Have you ever been unable to move your arms or legs after being hit or falling? | | |
| 40. Have you ever become ill while exercising in the heat? | | |
| 41. Do you get frequent muscle cramps when exercising? | | |
| 42. Do you or someone in your family have sickle cell trait or disease? | | |
| 43. Have you had any problems with your eyes or vision? | | |
| 44. Have you had any eye injuries? | | |

| | | | | | |
|---|---|---|---|---|---|
| 15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator? | 45. Do you wear glasses or contact lenses? | | | | |
| 16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? | 46. Do you wear protective eyewear, such as goggles or a face shield? | | | | |
| **BONE AND JOINT QUESTIONS** | 47. Do you worry about your weight? | **Yes** | **No** | | |
| 17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game? | 48. Are you trying to or has anyone recommended that you gain or lose weight? | | | | |
| 18. Have you ever had any broken or fractured bones or dislocated joints? | 49. Are you on a special diet or do you avoid certain types of foods? | | | | |
| 19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? | 50. Have you ever had an eating disorder? | | | | |
| 20. Have you ever had a stress fracture? | 51. Do you have any concerns that you would like to discuss with a doctor? | | | | |
| 21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism) | **FEMALES ONLY** | | | | |
| 22. Do you regularly use a brace, orthotics, or other aid or device? | 52. Have you ever had a menstrual period? | | | | |
| 23. Do you have a bone, muscle, or joint injury that bothers you? | 53. How old were you when you had your first menstrual period? | | | | |
| 24. Do any of your joints become painful, swollen, feel warm, or look red? | 54. How many periods have you had in the last 12 months? | | | | |
| 25. Do you have any history of juvenile arthritis or connective tissue disease? | | | | | |

**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 athlete _____ Signature of parent/guardian _____ Date _____

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## PreparticipationPhysicalEvaluation

# PHYSICALEXAMINATIONFORM

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, and use condoms?

2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

**EXAMINATION**

Height

Weight

☐ Male
☐ Female

BP ☐ N

/

(

/

)

Pul
se

Vision
R 20/

L 20

Corrected
☐ Y

| MEDICAL | NORMAL | ABNORMAL FINDINGS |
|---|---|---|
| Appearance<br>• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) | | |
| Eyes/ears/nose/throat<br>• Pupils equal<br>• Hearing | | |
| Lymph nodes | | |
| Heart [a]<br>• Murmurs (auscultation standing, supine, +/- Valsalva)<br>• Location of point of maximal impulse (PMI) | | |
| Pulses<br>• Simultaneous femoral and radial pulses | | |
| Lungs | | |
| Abdomen | | |
| Genitourinary (males only)[b] | | |
| Skin<br>• HSV, lesions suggestive of MRSA, tinea corporis | | |
| Neurologic [c] | | |
| **MUSCULOSKELETAL** | | |
| Neck | | |
| Back | | |
| Shoulder/arm | | |
| Elbow/forearm | | |

| | | |
|---|---|---|
| Wrist/hand/fingers | | |
| Hip/thigh | | |
| Knee | | |
| Leg/ankle | | |
| Foot/toes | | |
| Functional<br>• Duck-walk, single leg hop | | |

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam. [b]Consider GU exam if in private setting. Having third party present is recommended. [c]Consider cognitive evaluation or baseline neuropsychiatric testing if history of significant concussion.

☐ 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 preparticipation physical evaluation. The athlete 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. If conditions arise after the athlete 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 (print/type)

_____ Date _____

Address _____ Phone

_____

Signature of physician

_____, MD or DO

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# KENTON COUNTY SCHOOLS

## ATHLETICS, CHEERLEADING, OR BAND PARTICPATION RELEASE OF LIABILITY FORM

Board policy requires that students participating on a school sponsored team, cheerleading squad, or in the band, must have medical insurance. Students will not be allowed to participate in practices, tryouts, or games until proof of insurance is provided to the school. Families are encouraged to review their current health insurance policy to assure that the coverage is adequate. Students without insurance must purchase the insurance plan offered through the school before they will be permitted to participate.

In addition to providing medical insurance, parents/guardians must also assume responsibility for any other expenses that may result from an accident or injury during extracurricular activities. Other expenses may

include ambulance fees, medical plan co-payment, or insurance deductible fees. THE Kentucky High School Athletic Association (KHSAA) catastrophic insurance plan will continue to cover students in situations where medical expenses exceed $25,000.00.

❖ Please check below indicating that the following items were received.

☐ A copy of Voluntary Student Accident Insurance (supplementary insurance) was received. This insurance must be purchased in the event you do not have insurance for your child or supplementary insurance can be purchased through this policy to cover expenses not covered by the child's policy.

☐ Information from the Council on Disease Control (CDC) Heads-up concussion fact sheet for athletes was received.

☐ Information from the Council on Disease Control (CDC) Heads-up concussion fact sheet for parents was received.

Student's Full Name _____ Activity or Sport _____
Parent/Guardian Signature _____ Date _____

☐ If the student is an athlete or cheerleader, this waiver is to be attached to the KHSAA form on information of the last physical examination and proof of insurance. It should be turned in to the athletic director's office at the school where it will be kept on file for future reference. If the student is a band student, proof of insurance and this waiver must be kept in the band director's office.

**HEALTH CONDITIONS REQUIRING EMERGENCY MEDICATION ADMINISTRATION**

Student Name_____ Grade_____

School_____

Sport(s) participating in:
Fall: _____
Winter: _____
Spring: _____ Summer: _____

Has your child been diagnosed with any of the medical conditions listed below?

| | | | | | |
|---|---|---|---|---|---|
| Life-Threatening Allergy | ____no | ____yes | Is an Epipen Ordered? | ____no | ____yes |
| Diabetes | ____no | ____yes | Is Glucagon ordered? | ____no | ____yes |
| Seizures | ____no | ____yes | Is Diastat ordered? | ____no | ____yes |
| Asthma | ____no | ____yes | Is an Inhaler ordered? | ____no | ____yes |

Other Important Health Information _____
_____

If you've indicated yes on a medical condition, please contact the coach and school nurse for additional information. A *Medication Authorization Form* must be completed for all students requiring medication.

Parent Signature: _____ Date: _____

Dear Parent or Guardian,

Any medication, prescription or non-prescription, which a student requires during school hours, should be delivered by a parent/guardian and given to the school nurse or secretary. Any medication found in a student's possession, including his/her backpack or locker, could result in suspension or expulsion. All unauthorized medications will be confiscated.

Please keep in mind that school is not the best place to administer medicines. Doses can be forgotten during the busy school day. If your child's medicine can be administered at home, please do so. Remember, the initial dose of a medication cannot be administered at school.

In order for the school to administer **<u>any</u>** medication to your student, you will need the following:

- *A **Kenton County School District Administration of Medication Permission Form** completed and signed by your child's physician. This form must also be signed by the parent/guardian. This form is attached or available in the school office or first aid room.*
- *Notes from parents requesting medication to be administered to students will not be accepted.*
- *We cannot accept telephone permission for medication administration from a physician Your doctor's office may fax the signed form to the school.*
- *Medication must be in the original container. All prescription medications must have the student's name on the label with directions for administration that match the permission form.*

If the above procedures are not followed, we will not be permitted to administer medication to your student at school.

Medications containing narcotics for pain relief or sedation should not be sent to school. For their own safety, children requiring this level of medication should remain at home until this medication is no longer required during the school day.

All unused medications not picked up from school by a parent within 5 days will be discarded. No medication will be sent home with students.

We appreciate your cooperation in this matter and hope you understand these procedures are for the safety of all of our students.

## Kenton County School District Administration of Medication Permission Form

Dear Parent/Guardian,

**If medication administration is required during the school day, whether prescription or non-prescription, this form must be completed and signed by both a physician and parent. For any questions, please contact the school nurse.**

All medications are kept in the first aid room and must be in the original container with label affixed. For prescription medication, your student's name must be on the label and the label must match the directions on this form. The initial dose of a medication cannot be administered at school. Pursuant to *KRS 158.834 and KRS 158.836*, the Board of Education policy permits a responsible, trained student to carry and/or self administer medication for asthma (inhaler), severe allergic reaction (Epi-pen), seizures (Diastat) or diabetes (Glucagon) on his/her person for immediate use in a life threatening situation with a written physician's order, parent request, school nurse and principal approvals. We accept the parent request and physician statement. We will permit and assist the student to be responsible, but reserve the right to withdraw the privilege if the student shows signs of irresponsible behavior or there is a safety risk. We will contact the parent as soon as possible in this event. A new form is required for any changes in medication orders. This form may be faxed to the school to the number listed above. **The duration of this form is for one school year only. SCHOOL YEAR: _____.**

Name: _____Date of Birth: _____ Grade: _____ALLERGIES: _____

**TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER**

Medication: _____ Dosage: _____ Directions: _____
Administration Time: Lunch ____ or _____Route: _____ Diagnosis/Condition: _____
Possible Side Effects: _____ Duration: Start_____ Stop_____

****In the case of an inhaler, Epipen, Diastat or Glucagon, student has received training to carry the inhaler or emergency medication and, in my opinion, may ____CARRY and/or ____ SELF ADMINSTER this medication. (Physician's Initial) Yes ___**

Medication: _____ Dosage: _____Directions: _____
Administration Time: Lunch ____ or _____Route: _____ Diagnosis/Condition: _____
Possible Side Effects: _____ Duration: Start_____ Stop_____
**** In the case of an inhaler, Epipen, Diastat or Glucagon, student has received training to carry the inhaler or emergency medication and, in my opinion, may ____CARRY and/or ____SELF ADMINSTER this medication. (Physician's Initial) Yes ___**

Medication: _____ Dosage: _____Directions: _____
Administration Time: Lunch ____ or _____Route: _____ Diagnosis/Condition: _____
Possible Side Effects: _____ Duration: Start_____ Stop_____
**** In the case of an inhaler, Epipen, Diastat or Glucagon, student has received training to carry the inhaler or emergency medication and, in my opinion, may ____CARRY and/or ____SELF ADMINSTER this medication. (Physician's Initial) Yes ___**

******PARENT/GUARDIAN AUTHORIZATION FOR SELF CARRY/SELF ADMINISTER ONLY******

I request that my child, named above, be permitted to: _____ carry _____ self-administer the above **emergency medication**. I take responsibility for this permission. I understand the medication must be in the original pharmacy container, labeled with name of student, prescribing health care provider, and medication; date of original prescription; strength and dose of medication; and directions for use.

_____ _____ _____ _____

**PARENT SIGNATURE** **DATE** **STUDENT SIGNATURE** **DATE**

During school hours, I understand teachers, assistants, nurses or other trained school personnel may be administering these medications according to the specified physician's order and district policy. Schools have established individual procedures for where and when the students receive their daily medications. The student has the ultimate responsibility of reporting daily for their medication.

**No medications will be sent home with students. All unused medications not picked up from the school by a parent within 5 days will be discarded**.

I give permission for the storage and administration of this medication by trained school personnel accompanying my student on a field trip or school related function in Kentucky and/or other states. In the case of field trips or school related functions, slight adaptations to the time the medication is administered may also be necessary. Unless indicated otherwise, student may self administer medication with school trained personnel supervision while on a field trip. I hereby release the Kenton County Board of Education and its employees from any claims or liabilities connected with their reliance on this permission and agree to indemnify, defend and hold them harmless from any claim or liability connected with such reliance.

_____ _____ _____

***Parent's Signature** Parent's Phone Date

_____ _____ _____

***Physician's Signature** Physician's Phone Date

_____ _____ _____

***Print Physician's Name** Physician's Address Fax Number

_____ _____ _____ (11/11)

Principal's Signature (For self-carry only) School Nurse Signature Date Form Rec'd in Office

# DIXIE HEIGHTS ATHLETIC HANDBOOK DRUG USE PREVENTION POLICY

The Dixie Heights Athletic Handbook is a guide for players and parents and can be found at dixieheightsathletics.com under Important Links. The Handbook contains our Drug and Alcohol Prevention Policy.

The General Assembly of the Commonwealth of Kentucky has deemed that usage by a minor (those under age of 21) of alcohol, tobacco, and non-prescription narcotics is illegal. However, we recognize that students make poor decisions and not permitting them to learn from their mistakes would go against

the very mission this school is dedicated to doing. Keeping the school mission in mind, the following sanctions will be imposed on any athlete violating the athletic program tobacco, alcohol, or drug policy:

**1st OFFENSE: Loss of 10% of season with assessment before reinstatement. Student is permitted to practice.**

**2nd OFFENSE: Loss of 50% of season with assessment before reinstatement. Student is permitted to practice and will be referred to school guidance office for counseling.**

**3rd OFFENSE: Student will be dismissed from team for remainder of season and will not be permitted to participate in any other sport during that school year.**

***Students may also face disciplinary action from K.C.B.E. and the Dixie Heights Administration which may include dismissal from team, if warranted. ***

I have read and understand the Dixie Heights High School Athletic Handbook.

**Parent/Guardian: _____ Date: _____**

**Athlete: _____ Date: _____**

**DIXIE HEIGHTS ATHLETIC BOOSTER MEMBERSHIP**
**For School Year 20____**

Parent's/Guardian's Name_____

Address_____

City_____State_____Zip_____

Phone_____E-Mail_____

Would you like to become more involved in Dixie Heights Athletic Boosters? Y__N__

Please list all students in your family that will be participating in a Dixie Heights sport this year and the sport they will be participating in.
(Football, Girls or Boys Soccer, Girls or Boys Cross Country, Girls or Boys Track, Volleyball, Girls or Boys Golf, Lacrosse, Cheerleading, Dance Team, Girls or Boys Basketball, Wrestling, Girls or Boys swim/Dive, Baseball, Fastpitch, Girls or Boys Tennis (other sport)

1. Student Athlete's Name_____Grade_____

   Sports_____

2. Student Athlete's Name_____Grade_____

   Sports_____

Please list any Additional Athletes on the back of form.

Membership Fee: $10.00 per family. This is for the entire current school year. Please make checks payable to Dixie Heights Athletic Boosters and complete membership form.
Payment must be included with the membership form and turned into you Coach, Team representative or sent directly to the school office c/o Dixie Heights Athletic Boosters.
Dixie Heights Athletic Boosters meet the second Monday of each month at 6:30 pm in the cafeteria at Dixie. Everyone is welcome and encouraged to attend.
The Dixie Heights Athletic Boosters is a non profit organization IRC 501 (c) (3) designed to be run by the parents for the benefit of the Athletic teams at Dixie Heights. The Athletic boosters work closely with the Coaches, team reps and school administration to help provide funds for additional team expenses. Each team is expected to fund its own Booster account through team fundraising efforts and with the assistance of the Athletic Boosters.

## ***FACT SHEET FOR PARENTS***

**WHAT IS A CONCUSSION?** A concussion is a brain injury. Concussions are caused by a bump or blow to the head. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious. You can't see a concussion. Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If your child reports any symptoms of concussion, or if you notice the symptoms yourself, seek medical attention right away.

**WHAT ARE THE SIGNS AND SYMPTOMS OF A CONCUSSION?**
**Signs Observed by Parents or Guardians** *If your child has experienced a bump or blow to the head during a game or practice, look for any of the following signs and symptoms of a concussion:*

- Appears dazed or stunned
- Forgets an instruction
- Moves clumsily
- Loses consciousness (even briefly)
- Is confused about assignment or position
- Is unsure of game, score, or opponent
- Answers questions slowly
- Shows behavior or personality changes

• Can't recall events prior to hit or fall • Can't recall events after hit or fall

**Symptoms Reported by Athlete**

• Headache or "pressure" in head • Nausea or vomiting
• Balance problems or dizziness • Double or blurry vision
• Sensitivity to light • Sensitivity to noise • Feeling sluggish, hazy, foggy, or groggy
• Concentration or memory problems • Confusion
• Does not "feel right"

**HOW CAN YOU HELP YOUR CHILD PREVENT A CONCUSSION?** Every sport is different, but there are steps your children can take to protect themselves from concussion.

• Ensure that they follow their coach's rules for safety and the rules of the sport.
• Encourage them to practice good sportsmanship at all times.
• Make sure they wear the right protective equipment for their activity (such as helmets, padding, shin guards, and eye and mouth guards). Protective equipment should fit properly, be well maintained, and be worn consistently and correctly.
• Learn the signs and symptoms of a concussion.

**WHAT SHOULD YOU DO IF YOU THINK YOUR CHILD HAS A CONCUSSION?**

**1. Seek medical attention right away.** A health care professional will be able to decide how serious the concussion is and when it is safe for your child to return to sports.

**2. Keep your child out of play.** Concussions take time to heal. Don't let your child return to play until a health care professional says it's OK. Children who return to play too soon—while the brain is still healing—risk a greater chance of having a second concussion. Second or later concussions can be very serious. They can cause permanent brain damage, affecting your child for a lifetime.

**3. Tell your child's coach about any recent concussion.** Coaches should know if your child had a recent concussion in ANY sport. Your child's coach may not know about a concussion your child received in another sport or activity unless you tell the coach

# ***FACT SHEET FOR ATHLETES***

**WHAT IS A CONCUSSION?**

A concussion is a brain injury that:

• Is caused by a bump or blow to the head
• Can change the way your brain normally works
• Can occur during practices or games in any sport
• Can happen even if you haven't been knocked out
• Can be serious even if you've just been "dinged"

**WHAT ARE THE SYMPTOMS OF A CONCUSSION?**

• Headache or "pressure" in head
• Nausea or vomiting
• Balance problems or dizziness

- Double or blurry vision
- Bothered by light
- Bothered by noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty paying attention
- Memory problems
- Confusion
- Does not “feel right”

**WHAT SHOULD I DO IF I THINK I HAVE A CONCUSSION?**

**Tell your coaches and your parents.** Never ignore a bump or blow to the head even if you feel fine. Also, tell your coach if one of your teammates might have a concussion.

- **Get a medical check up.** A doctor or health care professional can tell you if you have a concussion and when you are OK to return to play.
- **Give yourself time to get better.** If you have had a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have a second concussion. Second or later concussions can cause damage to your brain. It is important to rest until you get approval from a doctor or health care professional to return to play.

**HOW CAN I PREVENT A CONCUSSION?** Every sport is different, but there are steps you can take to protect yourself.

- Follow your coach’s rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.
- Use the proper sports equipment, including personal protective equipment (such as helmets, padding, shin guards, and eye and mouth guards). In order for equipment to protect you, it must be: **>** The right equipment for the game, position, or activity **>** Worn correctly and fit well **>** Used every time you play

For more information and to order additional materials **free-of-charge**, visit: **www.cdc.gov/ConcussionInYouthSports**

For more detailed information on concussion and traumatic brain injury, visit: **www.cdc.gov/injury**