

ATHLETICS REQUIRED COMPETITION FORMS

Parents (or guardian) must complete/sign the following forms:

1. Parent/Guardian Agreement (Drug and Alcohol Form) - page 13
2. Permission to Participate in Interscholastic Sports - page 15
3. Sports Participation Health Record – page 17
4. Medical Examination Form – page 19
5. Emergency Medical Treatment Form - page 21
6. Parent/Guardian Agreement Regarding Performance Enhancing Drugs - page 47

Athletes must complete/sign the following forms:

1. Athlete Pledge (Drug and Alcohol Form) - page 13
2. Permission to Participate in Interscholastic Sports - page 15
3. Medical Examination Form – page 19
4. Athlete Pledge Regarding Performance Enhancing Drugs - page 47

Your physician (M.D.) must complete/sign the following form:

1. Medical Examination Form (must be completed after July 1 and prior to the beginning of the athletic season) – page 19

All forms must be returned to the coach before an athlete can practice or play.

DRUG-FREE TEAM ENVIROMENT

The Norwalk Public Schools Athletic Department discourages the use of any tobacco product, alcoholic beverage, or non-prescribed drug. To emphasize our position against tobacco, alcohol, and non-prescribed drugs, we support a **Drug-Free Team** environment. To participate in athletics at Brien McMahon/Norwalk High School, each athlete must abide by this policy. To show his/her support of the substance abuse prevention program each athlete will sign a pledge to his/her coach to abstain from using tobacco, alcohol, or non-prescribed drugs. In addition, we are asking the player's parent(s)/guardian(s) to sign an approval of their child's pledge.

RULE: No player will use, sell, or possess any tobacco, alcohol, stimulant, street-drug (including but not limited to marijuana, heroin, and cocaine), or non-prescribed drug. If the player chooses to violate the rules he/she will be subject to the following consequences:

A. Voluntary Referral - If a player "slips" and uses tobacco, alcohol, or non-prescribed drug but is not caught in a blatant violation, he/she may come forward on his or her own and speak to the coach privately. In this instance, **THERE IS NO SUSPENSION FROM THE TEAM**. The parents or guardians will be notified. The coach will work with the player. A referral for counseling will take place.

B. Concerned Friend Referral - If a teammate, a friend, or a parent finds out about a player's use of a forbidden substance and informs the coach, **THERE WILL BE NO SUSPENSION FROM THE TEAM**. The head coach will investigate the incident, discuss the situation with the player, and if necessary, will notify parents, guardians, and the school nurse for a referral for counseling.

These procedures can only occur once and may not be used after a blatant violation has taken place.

C. First Offense - Blatant Violation - If the player breaks the law and is arrested, shows up at a school function under the influence, or is found to be in possession of any tobacco, alcohol, or non-prescribed drug, the school's code of conduct will be followed.

D. First Offense - Blatant Violation or Second Violation after an A or B referral will warrant a two-game suspension.

E. For any subsequent violation of this policy, blatant or otherwise, the player will be suspended for the remainder of the season pending a hearing with the coach, athletic director, principal, school nurse, and parents/guardians.

Preventive and Intervention Education

Norwalk Public Schools will provide prevention and intervention education programs for student athletes. For more information on these programs, contact the coach, teacher, athletic director, school trainer, guidance counselor, school nurse, or the student-based health center.

References: Norwalk Public School's Student/Parent Handbook Norwalk Public School Board Policy #145.21 and #5131.6

**PARENT/GUARDIAN AGREEMENT
(Drug and Alcohol Form)**

I/we the parent(s) or guardian(s) of _____
have read and understand the Norwalk Public School Drug-Free Team Environment. I/we agree to
abide by the terms as outlined therein.

Parent/Guardian Signature Parent/Guardian Signature Date

**ATHLETE PLEDGE
(Drug and Alcohol Form)**

I _____ pledge to my coach to
abstain from any tobacco product, any alcoholic beverage, stimulants, street drugs
(including but not limited to marijuana, heroin, and cocaine) or any non-prescribed
drug during the Norwalk Public Schools athletic season. I realize that if I choose to
break this pledge I am responsible for the consequences my action brings. I also realize
that tobacco, alcohol, and non-prescribed drug-abuse prevention programs have my
best interest at heart. All I need to do is ask and help will be made available to me. In
addition, I understand the Norwalk Public Schools policy rules and know the
consequences that will result from my actions. I agree to abide by the terms as outlined.

Athlete Signature

Date

This form must be returned to the coach before the athlete can practice or play.

PERMISSION TO PARTICIPATE IN INTERSCHOLASTIC SPORTS

School Year _____ - _____

Students who participate in interscholastic sports are required to have a physical examination by a physician no earlier than July 1st of the current school year. Also, this permission form must be completed by a parent or guardian and returned to school.

Remember, no student may participate in practice or team play until these requirements are met.

IMPORTANT - SAVE UPPER PORTION

RETURN THIS BOTTOM PORTION TO COACH

I/We give our permission for (Name of Athlete) _____ to participate in organized high school 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 appropriate equipment, and strict observance of rules, injuries are still a possibility. On rare occasion, these injuries can be so severe as to result in total disability or even death. I/we acknowledge that I/we have read and understand this warning.

I/we have read the Athletic Handbook for Athletes and Parents and understand the rules and regulations governing Norwalk Public School high school athletics. I/we agree to abide by all terms and regulations as outlined therein.

Parent/Guardian Signature

Date

Athlete Signature

Date

This form must be returned to the coach before the athlete can practice or play

SPORTS PARTICIPATION HEALTH RECORD FOR NORWALK PUBLIC SCHOOLS

This evaluation is only to determine readiness for sports participation. It should not be used as a substitute for regular health maintenance examinations.

THIS SIDE MUST BE COMPLETED BY PARENT OR GUARDIAN AND STUDENT BEFORE BEING BROUGHT TO THE DOCTOR'S OFFICE.

NAME _____ AGE _____ SEX _____ SCHOOL _____

ADDRESS _____ PHONE _____ GRADE _____

SPORTS BEING PLAYED (1) _____ (2) _____ (3) _____

MEDICAL HISTORY - (To be completed by student and parent or guardian)

1 Do you have any allergies? (drug, food, insect stings, etc.) _____ YES; list: _____ NO

2 Are you currently taking any drugs or medications including steroids or protein supplements? (daily or occasionally) _____ YES; list: _____ NO

3 Is a physician or other health care professional presently treating you for any condition? _____ YES; explain: _____ NO

4 Have you ever been advised by a doctor not to participate in any sport? _____ YES; explain: _____ NO

5 Do you have any chronic conditions, disorders, or diseases?

Check those applicable or _____ NO _____ Asthma _____ Bleeding Disorders _____ Diabetes _____ Epilepsy (seizures)

_____ Hepatitis (liver disease) _____ Hypertension (high blood pressure) _____ Sickle Cell Anemia _____
Other _____ Mononucleosis - _____ Yr. _____ Kawasaki's Disease _____ Handicap (describe) _____

Please check where applicable if you have had any of the following:

YES NO YES NO

Head injury, concussion, or been unconscious Eye injury or retinal detachment If yes, how many times _____ Headaches more than once a week Blurred vision or vision in one eye only

Lack of feeling or numbness in any part of body Wear glasses or contacts Heat exhaustion or heat stroke Hearing loss or impairment in one or both ears Difficulty running 1/2 mile without stopping Tubes in ears or a perforated eardrum Chest pain, dizziness, or passing out during exercise False teeth, caps, or braces Coughing, wheezing, or gasping for breath with exercise or Nose bleeds for no reasons

cold weather Smoke cigarettes or chew tobacco Bruising easily or taking a long time to stop bleeding when cut Heart problem, murmur, or arrhythmia Diarrhea more than once a week Family member with a heart attack under age 50 Black or bloody bowel movements (stools) Loss or gain of more than 10 lbs. in last year Kidney disease or dark, brown, or bloody urine Special diet for medical reasons Less than two kidneys or, in males, two testicles *For female participants:* Lump(s) in arm pit or groin Absent or irregular monthly periods Rash or skin problem Disabling cramps with menstrual periods Neck, spine, or low back injury or pain

Have you ever been hospitalized for medical or surgical reasons? YES ___ NO ___

If yes, provide the following information:

REASON	YEAR	HOSPITAL
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Please carefully list below any injury (nerve, muscle, bone, or joint) you have had that did not allow you to participate in regular activity for a week or more? INJURED AREA YEAR SIDE TYPE RESOLVED (knee, hamstring, neck, shin, etc.) (R, L) (fracture, sprain, swelling, pinched nerve, etc.) YES NO

STUDENT AND PARENT OR GUARDIAN:

We hereby state that we have reviewed this medical history and found the information supplied above to be correct to the best of our knowledge.

STUDENT SIGNATURE _____ **DATE** _____
Norwalk Public Schools Norwalk, CT

PARENT OR GUARDIAN SIGNATURE _____ **DATE** _____

MEDICAL EXAMINATION FORM

To Be Completed By a Medical Doctor or His Designee and Returned to the School. This form must be received and cleared by the school nurse for the student to be eligible to practice and play.

NAME _____ DATE OF BIRTH _____

GENERAL EXAM

	Normal	Abnormal Findings
APPEARANCE		
SKIN		
HEENT		
RESPIRATORY		
CARDIOVASCULAR		
	Arrhythmia	
	Murmur	
ABDOMEN		
SPINE		
NEUROLOGICAL		
GENITALIA (hernia)		
SUMMARY:		
PHYSICAL MATURITY (TANNER STAGE) 1 2 3 4 5		

HEIGHT _____ WEIGHT _____
 BLOOD PRESSURE _____ PULSE _____
 HCT/HGB _____ URINALYSIS _____
 Protein ____ Blood ____ Glucose _____ VISUAL ACUITY
 _____ RIGHT _____ LEFT
 CORRECTED TO _____ RIGHT _____ LEFT
 HEARING _____

BODY FAT (Optional) = _____ %
 CHOLESTEROL (Optional) = _____

LAST TETANUS BOOSTER Date: _____
 LAST MEASLES (MMR) BOOSTER Date: _____
 OTHER IMMUNIZATIONS Date: _____

ORTHOPEDIC EXAM MUSCULOSKELETAL EVALUATION TO INCLUDE RANGE OF MOTION, STRENGTH, FLEXIBILITY

	Normal	Abnormal Findings
NECK		
SPINE		
SHOULDERS		
ARMS/HANDS		
HIPS		
THIGHS		
KNEES		RECOMMENDATIONS
ANKLES		

WEIGHT LOSS/GAIN _____ MEDICATIONS _____ STRENGTHENING _____
 _____ SPECIAL EQUIPMENT _____ STRETCHING _____
 BRACING/TAPING _____ CONDITIONING (Endurance) _____

I certify that on this date I have examined this student and that, on the basis of the examination requested by the school authorities and the student's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities except those listed below:

 M.D.
 SIGNATURE OF MEDICAL DOCTOR DATE TELEPHONE MEDICAL DOCTOR (PRINT/STAMP)

This form was developed and approved by: Connecticut Chapter, Committee on Sports Medicine – American Academy of Pediatrics
 Connecticut Chapter, Committee on School Health – American Academy of Pediatrics The Connecticut State Medical Society
 Committee on the Medical Aspects of Sports

_____ Parent/Guardian _____ Student

This form must be returned to the coach before the athlete can practice or play.

EMERGENCY MEDICAL TREATMENT FORM FOR HIGH SCHOOLS

In the event reasonable attempts to contact me or the persons whose names and telephone numbers may be listed below are unsuccessful, I, hereby, authorize the administering of emergency medical treatment to my child by a duly licensed physician or dentist.

PART I

Date Student's Name (Please Print) Signature of Parent/Guardian

Emergency Contact

1. _____ Phone # _____
2. _____ Phone # _____
3. _____ Phone # _____

**IF YOU DO NOT COMPLETE PART I, IT IS
IMPERATIVE THAT YOU COMPLETE PART II**

PART II

I DO NOT consent to the administering of emergency medical treatment to my child in the event of illness or injury.

Date Signature of Parent/Guardian

Does your child have a medical condition that we should be aware of? If so, please describe the condition below.

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INSURANCE CLAIM FORM

How to File a Claim

We the parent(s)/guardian(s) of _____ have read the Norwalk Public Schools Policy on anabolic steroids and the CIAC rules regarding performance enhancing drugs (pages 43 - 46). We understand the policy and rules and agree to abide by the terms as outlined. .

Parent/Guardian Signature Parent/Guardian Signature Date

ATHLETE PLEDGE REGARDING THE USE OF PERFORMANCE ENHANCING DRUGS

The CIAC allows member schools to make exceptions for those student-athletes with a documented medical history demonstrating the need for regular use of substances that are banned in this policy. These identified substances shall be medically prescribed by the student-athlete's doctor for therapeutic purposes. The documentation should contain information as to the diagnosis, medical history, and dosage prescribed.

PARENT/GUARDIAN INFORMATION Father/Guardian Name

Mother/Guardian Name _____ Address _____

Address _____ City/State/Zip _____

City/State/Zip _____ Home Phone _____

Home Phone _____ Is father employed? Y/N If
yes, fill out Section A. Is mother employed? Y/N If yes, fill out Section B. **SECTION A (Insured/Father) SECTION B (Spouse/Mother)**
Employer _____ Employer _____

Address _____ Address _____

City/State/Zip _____ City/State/Zip _____

Phone _____ Phone _____

Insurance Company _____ Insurance Company _____

Policy # _____ Policy # _____

MEDICAL INFORMATION AUTHORIZATION ASSIGNMENT OF BENEFITS You are hereby authorized to furnish at the request of and to Bob McCloskey Insurance and their representatives information which you may possess, including findings and treatments rendered, x-rays and copies of all hospital or medical records, all occasioned by professional services and hospital care rendered on my behalf.

The foregoing authorization is granted with the understanding that any legal rights I may ordinarily have to claim communications between us as privileged are hereby expressly and voluntarily waived. A photocopy of this authorization will be considered as effective and valid as the original.

PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE (HOSPITAL, PHYSICIAN, AND OTHERS), UNLESS A PAID RECEIPT OR STATEMENT ACCOMPANIES THE BILL AT THE TIME THE CLAIM IS SUBMITTED.

Claimant or Authorized Person's Signature _____ Date _____

