INFORMACIÓN DE DEPORTES 2019-2020

PVSchools Athletics

ESTUDIANTE ID #:

MARQUE TODAS LAS QUE APLICAN									
BÁDMINTON		CAMPO TRAVIESA		FÚTBOL (SOCCER)		NATACIÓN/ CLAVADOS		VOLEIBOL	
BÉISBOL		FÚTBOL AMERICANO		SOFTBALL		TENIS		LUCHA LIBRE	
BALONCESTO		GOLF		SPIRITLINE		PISTA		UNIFICADO	

OFFICE USE ONLY/ USO DE OFICINA SOLAMENTE			
EMERGENCY CARD		CLEARNACE ISSUED	
I C VIDEO		PHYSICAL	
BRAIN BOOK		DATE COMPLETED	

POR FAVOR LEA CUIDADOSAMENTE Y COMPLETAR TODAS LAS PÁGINAS Y LAS LÍNEAS DE LA FIRMA

Nombre del estudiante:	Fecha de nacimiento: / /	Género:	Grado:
Domicilio:	Ciudad:	Código postal:	
Nombre de uno de los padres:	Teléfono de casa:	Teléfono celular:	
Nombre del tutor legal (si no vive con los padres):	Parentesco:	Teléfono:	
Escuela(s) a la(s) que asistió el año pasado:			

SI NO SE PUEDE CONTACTAR A LOS PADRES/TUTORES LEGALES EN CASO DE UNA EMERGENCIA, PUEDEN COMUNICARSE CON:

Nombre:	Teléfono de casa:	Teléfono celular:
Médico primario:		Médico Teléfono:
Hospital de preferencia:	Alergias:	

Por medio de la presente doy permiso a los entrenadores o médicos del equipo, de usar su juicio para asegurar ayuda médica en caso de emergencia.
Seguro Médico: Estudiante atleta debe tener seguro médico. EL DISTRITO ESCOLAR UNIFICADO DE PARADISE VALLEY NO PROVEE SEGURO MEDICO PARA ESTUDIANTES ATLETAS. Los padres deben obtener seguro médico, ya que ellos son responsables de los gastos médicos que resulten de la participación en actividades deportivas. Los padres de familia deben proporcionar la información del seguro para ayudar a los entrenadores, instructores, al personal deportivo y al equipo médico en caso de que un alumno deportista requiera asistencia médica debido a una lesión.

He comprado el seguro escolar:	**SÍ**	**NO**	Tengo mi propio seguro:	**SÍ**	**NO**
Compañía de seguros:			**Numero De Poliza:**		

BRAINBOOK: Por requisito de la AIA (Arizona Interscholastic Asociación), todos los deportistas deben tomar el curso en línea de educación sobre conmociones cerebrales, tomar el examen al finalizar el curso y obtener un puntaje mínimo de 80% antes de que se les permita competir en un deporte.
Deben de imprimir el certificado d cumplimiento y entregarlo a la escuela. El sitio web para tomar el curso es: https://aiaacademy.org/. Solo es necesario tomar el curso una vez antes de su primera participación en actividades deportivas en el distrito escolar.

Consentimiento para que se realicen análisis antidrogas a los estudiantes: HE/HEMOS RECIBIDO, LEIDO Y COMPRENDIDO el Manual para los padres y alumnos sobre el Consentimiento Informado y Normas y procedimientos de las pruebas de detección de drogas al azar del Distrito Escolar Unificado Paradise Valley. Daré permiso a mi hijo(a) de participar en este programa contra drogas durante el tiempo que forme parte del equipo de deportistas de la escuela secundaria del Distrito Escolar Unificado Paradise Valley, y por la presente me adhiero voluntariamente a los términos del Programa de Prevención de drogas. Acepto el método para obtener muestras de orina, pruebas y análisis de dichas muestras y todos los otros aspectos del programa. Estoy de acuerdo en cooperar proporcionando las muestras que pudieran requerirse de vez en cuando.
También estoy de acuerdo y doy permiso de revelar las muestras, pruebas y resultados como lo indica el programa. Doy este consentimiento de conformidad con los estatutos estáteles y federales referentes a la privacidad y las provisiones constitucionales y de la ley común sobre la privacidad y es una exención del derecho a no revelar dichas pruebas y resultados, sol hasta el punto en que lo autorice el programa.

Permiso De Transporte: Doy/Damos permiso al distrito escolar de transportar a nuestro(a) hijo(a) en vehículos de distrito a juegos o practicas fuera de la escuela según sea necesario.

Uso del equipo: El alumno deportista tiene la responsabilidad de cuidar y devolver todo el equipo que la escuela secundaria le asigno. ENTIENDO/ENTENDEMOS y estamos de acuerdo con que todo el equipo asignado a nuestro(a) hijo(a) es propiedad de las escuela secundaria y debe devolverse en buenas condiciones. Todo equipo perdido, dañado o robado debe ser reemplazado y por lo tanto, es necesario reembolsar al Departamento de Deportes dicho costo.

Código de conducta/manual para padres y estudiantes: /HE/HEMOS leído y comprendemos la información del Manual sobre el consentimiento informado, incluyendo la declaración de acuerdo de PVUSD y el Código de conducta de la secundaria, y do fe del cumplimiento de todas las reglas y requerimientos para los deportistas, que se encuentran en el manual.

Autorización de usar el nombre Y/O Fotografías: Excepto si aparece mi firma en la línea de abajo del párrafo en negritas, DOYDAMOS autorización para que el distrito escolar tome fotografías de mi/nuestro hijo(a) durante su participación en eventos deportivos y que dicho material fotográfico sea utilizado en diferentes publicaciones y formatos de los medios de comunicación, incluyendo, pero no limitado a páginas Web, artículos en el periódico, publicaciones y/o boletines informativos de distrito escolar. YO/NOSOTROS también aceptamos que en estas fotografías se identifique a mi/nuestro hijo(a) con su nombre completo. Por medio de mi/nuestra firma a continuación, notificamos que no queremos que el distrito escolar utilice el nombre y/o la imagen de mi/nuestro hijo(a) en ningún formato o publicación y por la presente yo/nosotros no otorgamos permiso descrito en el párrafo inmediatamente anterior.

FIRMA DE UNO DE LOS PADRES/TUTOR LEGAL:	**FECHA:**

Vídeo de consentimiento de los padres en caso de lesiones deportivas: Antes de participar en el primer evento deportivo organizado por el distrito escolar, cada alumno junto con uno de sus padres **tienen que ver**, en línea el video Parent Consent Sports Injury Video sobre el consentimiento de los padres en caso de lesiones deportivas. Para ver este video visiten https://www.youtube.com/watch?v=rtTJR9KNVWQ&feature=youtu.be.
Al Firmar Aquí Confirmo que mi hijo(a) y yo vimos el video, y entendemos los riesgos de participar en los deportes del distrito.

FIRMA DE UNO DE LOS PADRES/TUTOR LEGAL:	**FECHA:**

DECLARACION

HE/HEMOS LEIDO, COMPRENDEMOS Y CUMPLIREMOS CON LAS AFIRMACIONES CONTENIDAS EN TODAS LAS PAGINAS DE ESTE PAQUETE.

FIRMA DE UNO DE LOS PADRES/TUTOR LEGAL:	**FECHA:**
FIRMA DEL ESTUDIANTE:	**FECHA:**

ARIZONA INTERSCHOLASTIC ASSOCIATION
7007 N. 18TH ST., PHOENIX, ARIZONA 85020-5552
PHONE: (602) 385-3810

2019-20 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

(The parent or guardian should fill out this form with assistance from the student-athlete) Exam Date: _____

Name: _____
Home Address: _____
Phone: _____
Date of Birth: _____
Age: _____
Gender: _____
Grade: _____
School: _____
Sport(s): _____
Personal Physician: _____
Hospital Preference: _____

In case of emergency contact:
Name: _____
Relationship: _____
Phone (Home): _____
Phone (Work): _____
Phone (Cell): _____

Name: _____
Relationship: _____
Phone (Home): _____
Phone (Work): _____
Phone (Cell): _____

Explain "Yes" answers on the following page.
Circle questions you don't know the answers to.

	Y	N
1) Has a doctor ever denied or restricted your participation in sports for any reason?		
2) Do you have an ongoing medical conditional (like diabetes or asthma)?		
3) Are you currently taking any prescription or nonprescription (over-the-counter) medicines or supplements? (Please specify): _____		
4) Do you have allergies to medicines, pollens, foods or stringing insects? (Please specify): _____		
5) Does your heart race or skip beats during exercise?		
6) Has a doctor ever told you that you have (check all that apply): High Blood Pressure A Heart Murmur High Cholesterol A Heart Infection		
7) Have you ever spent the night in a hospital?		
8) Have you ever had surgery?		
9) Have you ever had an injury (sprain, muscle/ligament tear, tendinitis, etc.) that caused you to miss a practice or game? (If yes, check affected area in the box below in question 11)		
10) Have you had any broken/fractured bones or dislocated joints? (If yes, check affected area in the box below in question 11)		
11) Have you had a bone/joint injury that required X-rays, MRI, CT, surgery, injections, rehabilitation physical therapy, a brace, a cast or crutches? (If yes, check affected area in the box below)		

Head	Neck	Shoulder	Upper Arm	Elbow	Forearm
Hand/Fingers	Chest	Upper Back	Lower Back	Hip	Thigh
Knee	Calf/Shin	Ankle	Foot/Toes		

	Y	N
12) Have you ever had a stress fracture?		
13) Have you ever been told that you have, or have you had an X-ray for atlantoaxial (neck) instability?		
14) Do you regularly use a brace or assistive device?		
15) Has a doctor told you that you have asthma or allergies?		
16) Do you cough, wheeze or have difficulty breathing during or after exercise?		
17) Is there anyone in your family who has asthma?		
18) Have you ever used an inhaler or taken asthma medication?		
19) Were you born without, are you missing, or do you have a nonfunctioning kidney, eye, testicle or any other organ?		
20) Have you had infectious mononucleosis (mono) within the last month?		
21) Do you have any rashes, pressure sores or other skin problems?		
22) Have you had a herpes skin infection?		
23) Have you ever had an injury to your face, head, skull or brain (including a concussion, confusion, memory loss or headache from a hit to your head, having your "bell rung" or getting "dinged")?		
24) Have you ever had a seizure?		
26) Have you ever had numbness, tingling or weakness in your arms or legs after being hit, falling, stingers or burners?		
27) While exercising in the heat, do you have severe muscle cramps or become ill?		
28) Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?		
29) Have you ever been tested for sickle cell trait?		
30) Have you had any problems with your eyes or vision?		
31) Do you wear glasses or contact lenses?		
32) Do you wear protective eyewear, such as goggles or a face shield?		
33) Are you happy with your weight?		
34) Are you trying to gain or lose weight?		
35) Has anyone recommended you change your weight or eating habits?		
36) Do you limit or carefully control what you eat?		
37) Do you have any concerns that you would like to discuss with a doctor?		

Females Only

	Y	N
38) Have you ever had a menstrual period?		
39) How old were you when you had your first menstrual period?	_____	
40) How many periods have you had in the last year?	_____	

Explain "Yes" Answers Here

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2019-20 ANNUAL PREPARTICIPATION PHYSICAL EXAMINATION

The physician should fill out this form with assistance from the parent or guardian.)

Student Name: _____ Date of Birth: _____

Patient History Questions: Please Tell Me About Your Child...

	Y	N
1) Has your child fainted or passed out DURING or AFTER exercise, emotion or startle?		
2) Has your child ever had extreme shortness of breath during exercise?		
3) Has your child had extreme fatigue associated with exercise (different from other children)?		
4) Has your child ever had discomfort, pain or pressure in his/her chest during exercise?		
5) Has a doctor ever ordered a test for your child's heart?		
6) Has your child ever been diagnosed with an unexplained seizure disorder?		
7) Has your child ever been diagnosed with exercise-induced asthma not well controlled with medication?		

Family History Questions: Please Tell Me About Any Of The Following In Your Family...

	Y	N
8) Are there any family members who had sudden/unexpected/unexplained death before age 50? (including SIDS, car accidents drowing or near drowning)		
9) Are there any family members who died suddenly of "heart problems" before age 50?		
10) Are there any family members who have unexplained fainting or seizures?		
11) Are there any relatives with certain conditions, such as:		

	Y	N		Y	N
Enlarged Heart			Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT)		
Hypertrophic Cardiomyopathy (HCM)			Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)		
Dilated Cardiomyopathy (DCM)			Marfan Syndrome (Aortic Rupture)		
Heart Rhythm Problems			Heart Attack, Age 50 or Younger		
Long QT Syndrome (LQTS)			Pacemaker or Implanted Defibrillator		
Short QT Syndrome			Deaf at Birth		
Brugada Syndrome					

Explain "Yes" Answers Here

I hereby state that, to the best of my knowledge, my answers to all of the above questions are complete and correct. Furthermore, I acknowledge and understand that my eligibility may be revoked if I have not given truthful and accurate information in response to the above questions.

_____ _____ _____
Signature of Athlete Signature of Parent/Guardian Date

_____ _____
Signature of MD/DO/ND/NMD/NP/PA-C/CCSP Date

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2019-20 ANNUAL PREPARTICIPATION PHYSICAL EXAMINATION

Name: _____ Date of Birth: _____
Age: _____ Sex: _____
Height: _____ Weight: _____
% Body Fat (optional): _____ Pulse: _____
BP: ____ / ____ (____ / ____,____ / ____)
Vision: R20/____ L20/____ Corrected: Y N
Pupils: Equal Unequal

	Normal	Abnormal Findings	Initials *
Medical			
Appearance			
Eyes/Ears/Throat/Nose			
Hearing			
Lymph Nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary &			
Skin			
Musculoskeletal			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hands/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			

* - Multi-examiner set-up only
& - Having a third party present is recommended for the genitourinary examination

NOTES:

Cleared Without Restriction
Cleared With Following Restriction: _____
Not Cleared For: All Sports Certain Sports: _____ Reason: _____
Recommendations: _____

Name of Physician (Print/Type): _____ Exam Date: _____
Address: _____ Phone: _____
Signature of Physician: _____, MD/DO/ND/NMD/NP/PA-C/CCSP

Arizona Interscholastic Association, Inc.

Mild Traumatic Brain Injury (MTBI) / Concussion

Annual Statement and Acknowledgement Form

I, _____ (student), acknowledge that I have to be an active participant in my own health and have the direct responsibility for reporting all of my injuries and illnesses to the school staff (e.g., coaches, team physicians, athletic training staff). I further recognize that my physical condition is dependent upon providing an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries and/or disabilities experienced before, during or after athletic activities.

By signing below, I acknowledge:

- My institution has provided me with specific educational materials including the CDC Concussion fact sheet (http://www.cdc.gov/concussion/HeadsUp/youth.html) on what a concussion is and has given me an opportunity to ask questions.
- I have fully disclosed to the staff any prior medical conditions and will also disclose any future conditions.
- There is a possibility that participation in my sport may result in a head injury and/or concussion. In rare cases, these concussions can cause permanent brain damage, and even death.
- A concussion is a brain injury, which I am responsible for reporting to the team physician or athletic trainer.
- A concussion can affect my ability to perform everyday activities, and affect my reaction time, balance, sleep, and classroom performance.
- Some of the symptoms of concussion may be noticed right away while other symptoms can show up hours or days after the injury.
- If I suspect a teammate has a concussion, I am responsible for reporting the injury to the school staff.
- I will not return to play in a game or practice if I have received a blow to the head or body that results in concussion related symptoms.
- I will not return to play in a game or practice until my symptoms have resolved AND I have written clearance to do so by a qualified health care professional.
- Following concussion the brain needs time to heal and you are much more likely to have a repeat concussion or further damage if you return to play before your symptoms resolve.

Based on the incidence of concussion as published by the CDC the following sports have been identified as high risk for concussion; baseball, basketball, diving, football, pole vaulting, soccer, softball, spiritline and wrestling.

I represent and certify that I and my parent/guardian have read the entirety of this document and fully understand the contents, consequences and implications of signing this document and that I agree to be bound by this document.

Student Athlete:

Print Name: _____ Signature: _____

Date: _____

Parent or legal guardian must print and sign name below and indicate date signed.

Print Name: _____ Signature: _____

Date: _____

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2019-20 CONSENT TO TREAT FORM

Parental consent for minor athletes is generally required for sports medicine services, defined as services including, but not limited to, evaluation, diagnosis, first aid and emergency care, stabilization, treatment, rehabilitation and referral of injuries and illnesses, along with decisions on return to play after injury or illness. Occasionally, those minor athletes require sports medicine services before, during and after their participation in sport-related activities, and under circumstances in which a parent or legal guardian is not immediately available to provide consent pertaining to the specific condition affecting the athlete. In such instances it may be imperative to the health and safety of those athletes that sports medicine services necessary to prevent harm be provided immediately, and not be withheld or delayed because of problems obtaining consent of a parent/guardian.

Accordingly, as a member of the Arizona Interscholastic Association (AIA), _____ (name of school or district) requires as a pre-condition of participation in interscholastic activities, that a parent/guardian provide written consent to the rendering of necessary sports medicine services to their minor athlete by a qualified medical provider (QMP) employed or otherwise designated by the school/district/AIA, to the extent the QMP deems necessary to prevent harm to the student-athlete. It is understood that a QMP may be an athletic trainer, physician, physician assistant or nurse practitioner licensed by the state of Arizona (or the state in which the student-athlete is located at the time the injury/illness occurs), and who is acting in accordance with the scope of practice under their designated state license and any other requirement imposed by Arizona law. In emergency situations, the QMP may also be a certified paramedic or emergency medical technician, but only for the purpose of providing emergency care and transport as designated by state regulation and standing protocols, and not for the purpose of making decisions about return to play.

PLEASE PRINT LEGIBLY OR TYPE

"I, _____, the undersigned, am the parent/legal guardian of, _____, a minor and student-athlete at _____ (name of school or district) who intends to participate in interscholastic sports and/or activities.

I understand that the school/district/AIA employs or designates QMP's (as defined above) to provide sports medicine services (as also defined above) to the school's interscholastic athletes before, during or after sport-related activities, and that on certain occasions there are sport-related activities conducted away from the school/district facilities during which other QMP's are responsible for providing such sports medicine services. I hereby give consent to any such QMP to provide any such sports medicine services to the above-named minor. The QMP may make decisions on return to play in accordance with the defined scope of practice under the designated state license, except as otherwise limited by Arizona law. I also understand that documentation pertaining to any sports medicine services provided to the above-named minor, may be maintained by the QMP. I hereby authorize the QMP who provides such services to the above-named minor to disclose such information about the athlete's injury/illness, assessment, condition, treatment, rehabilitation and return to play status to those who, in the professional judgment of the QMP, are required to have such information in order to assure optimum treatment for and recovery from the injury/illness, and to protect the health and safety of the minor. I understand such disclosures may be made to above-named minor's coaches, athletic director, school nurse, any classroom teacher required to provide academic accommodation to assure the student-athlete's recovery and safe return to activity, and any treating QMP.

If the parent believes that the minor is in need of further treatment or rehabilitation services for the injury/illness, the minor may be treated by the physician or provider of his/her choice. I understand, however, that all decisions regarding same day return to activity following injury/illness shall be made by the QMP employed/designated by the school/district/AIA.

Date: _____ Signature: _____

NORTH CANYON PINNACLE HORIZON SHADOW MOUNTAIN PARADISE VALLEY

CONSENTIMIENTO PARA TRATAR AL DEPORTISTA EN CASO DE EMERGENCIA

ATHLETICS CONSENT FOR EMERGENCY CARE/TREATMENT

Nombre del alumno:		
Fecha de Nacimiento: / /	No. De Identificación del Alumno:	Grado:
Deporte(s) de Otoño:	Deporte(s) de Invierno:	Deporte(s) de Primavera:

En caso de que ocurra una lesión deportiva o enfermedad al alumno deportista anteriormente mencionado durante su participación en una actividad deportiva autorizada en un plantel del Distrito Escolar Unificado Paradise Valley, doy mi autorización para que reciba cuidados adecuados y necesarios de un entrenador deportivo certificado o con licencia, médico u otro proveedor de servicios de salud que represente la División de Terapia Física para Pacientes no Internados del Hospital *Banner*. Adicionalmente, en el caso de que ocurra una emergencia médica y no se me pueda contactar, autorizo que el representante de salud de Terapia Física de *Banner* ordene que sea trasladado por servicio de ambulancia a las instalaciones médicas más cercanas. Asimismo, autorizo que el personal de dichas instalaciones médicas proporcione el tratamiento que considere necesario para el bienestar y salud del alumno deportista.

Nombre del padre de familia o tutor legal:		
Dirección:		
Números de teléfono del padre:	Primario:	Secundario:
Números de teléfono de la madre:	Primario:	Secundario:
EN CASO DE EMERGENCIA Y NO SE PUEDA CONTACTAR A LOS PADRES O TUTORES LEGALES, FAVOR DE CONTACTAR A:		
Nombre del pariente o amigo:		Teléfono:
Nombre del pariente o amigo:		Teléfono:
Médico Familiar:		Teléfono:
Hospital:		
Compañía de Seguros:		Número de Póliza:
FAVOR DE ANOTAR CUALQUIER CONDICIÓN MÉDICA/MEDICAMENTOS/ALERGIAS A CONTINUACIÓN:		

He leído con atención este acuerdo, entiendo el contenido en su totalidad y firmo por voluntad propia.

Firma del padre de familia/tutor legal: _____ Fecha: _____