

HERITAGE ACADEMY PARENT CONSENT AND EMERGENCY INFORMATION

My signature below indicates my permission for my scholar, _____, to participate in after school sports/activities at Heritage Academy. My signature also indicates that I have read and approve the medical treatment authorization.

EMERGENCY INFORMATION

Student Name: _____ Birthdate: _____ Age: _____

Father's Name: _____ Mother's Name: _____

Day Phone of Parents: Father _____ Mother: _____

Address: _____

Family Doctor: _____ Phone Number: _____

Allergies: _____

In an emergency, if the parents cannot be reached, please notify:

Name: _____ Phone Number: _____

MEDICAL TREATMENT AUTHORIZATION

In the event of illness or injury occurring to my child while participating in this activity, I hereby give my consent for medical or dental care deemed necessary by the attending health care provider or dentist. My child may be examined and any necessary procedures (medical, dental, or surgical), anesthesia or diagnostic procedures (lab or x-ray) may be performed under the supervision of a member of the hospital or medical office staff furnishing such services.

I understand that, in the event of other than minor illness or injury, reasonable effort will be made to contact me.

I understand that there is inherent risk in many activities, and I hold Heritage Academy harmless and not liable for injury or accident, which may occur in the course of such activities. I willingly and ultimately assume the risk of such injury or accident.

Parent/Guardian Name: _____

Signature: _____

Date: _____

Heritage Academy Charter School

Code of Conduct for Scholars and Parents

Participating in an athletic program at Heritage Academy is a privilege. With this privilege, scholar athletes are expected to adhere to a high standard of behavior. All scholar athletes shall abide by a code of ethics that will earn them the honor and respect that participation and competition affords. It is important for our athletes to realize they represent their families, the school and the community at all times. Scholar athletes act as role models for the younger scholars. Scholar athletes have a commitment to their teammates and coaches to be at their best physically, mentally and academically at all times.

Scholar athletes should promote a healthy lifestyle by not using any illegal or unhealthy substances including alcohol, tobacco and drugs or engage in any unhealthy techniques to gain, lose or maintain weight. It is expected that scholar athletes adhere to the Code of Conduct at all times, not just during the sport season.

It is important that a scholar athlete realize the great sacrifice by coaches, teammates, teachers, family and others in your behalf. Your gratitude is expressed by your respect!

Heritage academy issues a Scholar hand book that can be obtained from the front office or found online at www.hamesa.com

It is expected that all scholar athletes will respect and comply with the rules of Heritage Academy.

Scholar Athlete

ATHLETES MUST AGREE TO:

- Be to practice and games on time.
- Be responsible for any equipment and uniform issued to them and returning it as requested at the designated time and place. Scholar will replace misused, abused or lost equipment or be charged replacement value.
- Be respectful and encouraging towards your teammates. Do not belittle them for their mistakes or abilities. Be encouraging they are working hard too.
- Take responsibility to your academic eligibility and the tools to help you stay on track which will be offered by the coach.
- Help other teammates who may struggle in classes you excel in.
- Listen to your coaches while they are talking to you or another player. We do not want to talk over you.
- Not use or possess illegal substances including tobacco, alcohol, marijuana or drug paraphernalia.
- Not participate in any other act that results in the scholar athlete being charged with a crime or referred for juvenile delinquency.
- Notify one of the coaches of any teammate that might be struggling with issues contrary to our team standards.

Parents

PARENTS MUST AGREE TO:

- Have their athlete on time to practices and games.
- Help your athlete keep track of and in good condition any equipment and uniform issued to them. Replacement costs are not part of the participation fees.
- Not encourage belittling conversation towards players and/or coaches. Your comments are welcomed at the appropriate time.
- Cheer from the designated areas. A parent on the field makes coaching more difficult and is a distraction to all the players. It also makes it difficult for those behind to see. This includes half time.
- Share with the coach any concerns you might have about your athlete regarding sports, academics, or anything you feel would better help us understand him/her. We are a team-family. We want them to succeed
- Please respect the following times Pre-game (30 minutes before the game), the game (1st and 2nd halves), and post game (30 minutes after the game). This is NOT a good time for coaches to talk. We have lots to do regarding our team.

Parent signature: _____ **Athlete signature:** _____ **Date** _____

PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

REVISED 1-6-09

This MEDICAL HISTORY FORM must be completed **annually** by parent (or guardian) and student in order for the student to participate in athletic activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an athletic event.

Student's Name: (print) _____ Sex _____ Age _____ Date of Birth _____

Address _____ Phone _____

Grade _____ School _____

Personal Physician _____ Phone _____

In case of emergency, contact:

Name _____ Relationship _____ Phone (H) _____ (W) _____

Explain "Yes" answers in the box below. Circle questions you don't know the answers to. Any Yes answer to questions 1, 2, 3, 4, 5, or 6 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physician assistant, chiropractor, or nurse practitioner is required before any participation in UIL practices, games or matches**

<p>1. Have you had a medical illness or injury since your last check up or sports physical? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you been hospitalized overnight in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Have you ever passed out during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had chest pain during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you get tired more quickly than your friends do during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had racing of your heart or skipped heartbeats? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had high blood pressure or high cholesterol? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever been told you have a heart murmur? <input type="checkbox"/> Yes <input type="checkbox"/> No Has any family member or relative died of heart problems or of sudden unexpected death before age 50? <input type="checkbox"/> Yes <input type="checkbox"/> No Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome or other ion channelopathy (Brugada syndrome, etc), Marfan's syndrome, or abnormal heart rhythm? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? <input type="checkbox"/> Yes <input type="checkbox"/> No Has a physician ever denied or restricted your participation in sports for any heart problems? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Have you ever had a head injury or concussion? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever been knocked out, become unconscious, or lost your memory? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many times? _____ When was the last concussion? _____ How severe was each one? (Explain below) _____ Have you ever had a seizure? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have frequent or severe headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had numbness or tingling in your arms, hands, legs, or feet? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had a stinger, burner, or pinched nerve? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Are you missing any paired organs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Are you under a doctor's care? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Have you ever been dizzy during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Have you ever become ill from exercising in the heat? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Have you had any problems with your eyes or vision? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>13. Have you ever gotten unexpectedly short of breath with exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have seasonal allergies that require medical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>15. Have you ever had a sprain, strain, or swelling after injury? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you broken or fractured any bones or dislocated any joints? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, check appropriate box and explain below.</p> <table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> Head</td> <td><input type="checkbox"/> Elbow</td> <td><input type="checkbox"/> Hip</td> </tr> <tr> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/> Forearm</td> <td><input type="checkbox"/> Thigh</td> </tr> <tr> <td><input type="checkbox"/> Back</td> <td><input type="checkbox"/> Wrist</td> <td><input type="checkbox"/> Knee</td> </tr> <tr> <td><input type="checkbox"/> Chest</td> <td><input type="checkbox"/> Hand</td> <td><input type="checkbox"/> Shin/Calf</td> </tr> <tr> <td><input type="checkbox"/> Shoulder</td> <td><input type="checkbox"/> Finger</td> <td><input type="checkbox"/> Ankle</td> </tr> <tr> <td><input type="checkbox"/> Upper Arm</td> <td></td> <td><input type="checkbox"/> Foot</td> </tr> </table> <p>16. Do you want to weigh more or less than you do now? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you lose weight regularly to meet weight requirements for your sport? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>17. Do you feel stressed out? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Females Only</p> <p>19. When was your first menstrual period? _____ When was your most recent menstrual period? _____ How much time do you usually have from the start of one period to the start of another? _____ How many periods have you had in the last year? _____ What was the longest time between periods in the last year? _____</p> <p>An individual answering in the affirmative to any question relating to a possible cardiovascular health issue (question three above), as identified on the form, should be restricted from further participation until the individual is examined and cleared by a physician, physician assistant, chiropractor, or nurse practitioner.</p> <p>**EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary):</p> <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	<input type="checkbox"/> Head	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip	<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh	<input type="checkbox"/> Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Knee	<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Shin/Calf	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger	<input type="checkbox"/> Ankle	<input type="checkbox"/> Upper Arm		<input type="checkbox"/> Foot
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<input type="checkbox"/> Upper Arm		<input type="checkbox"/> Foot																	

It is understood that even though protective equipment is worn by the athlete, whenever needed, the possibility of an accident still remains. Neither the University Interscholastic League nor the school assumes any responsibility in case an accident occurs.

If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student.

If, between this date and the beginning of athletic competition, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide truthful responses could subject the student in question to penalties determined by the UIL

Student Signature: _____ Parent/Guardian Signature: _____ Date: _____

THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE OR CONTEST BEFORE, DURING OR AFTER SCHOOL.

For School Use Only:

This Medical History Form was reviewed by: Printed Name _____ Date _____ Signature _____

PREPARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAMINATION

Student's Name _____ Sex _____ Age _____ Date of Birth _____

Height _____ Weight _____ % Body fat (optional) _____ Pulse _____ BP _____/_____/_____ (_____/_____._____/_____)
brachial blood pressure while sitting

Vision R 20/_____ L 20/_____ Corrected: Y N Pupils: Equal Unequal

As a minimum requirement, this **Physical Examination Form** must be completed prior to junior high athletic participation and again prior to first and third years of high school athletic participation. It *must* be completed if there are yes answers to specific questions on the student's MEDICAL HISTORY FORM on the reverse side. * *Local district policy may require an annual physical exam.*

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in the supine position.			
Heart-Auscultation of the heart in the standing position.			
Heart-Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*station-based examination only

CLEARANCE

- Cleared
- Cleared after completing evaluation/rehabilitation for: _____

Not cleared for: _____ Reason: _____

Recommendations: _____

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner, will not be accepted.

Name (print/type) _____ Date of Examination: _____

Address: _____

Phone Number: _____

Signature: _____

Must be completed before a student participates in any practice, before, during or after school, (both in-season and out-of-season) or games/matches.

