

Katy Independent School District Athletic Participation Packet

- This packet must be completed in its **entirety** before a student participates in **any** try-out, practice, athletic class, open gym, open weight room, athletic competition, or travels with an athletic team for any purpose.
- The UIL form enclosed **must** be used for the physical exam per UIL rule. A new physical exam must be given prior to each school calendar year. Any physical administered prior to May 1, may not be valid after August 1.

KISD Athletic Guidelines and Code of Conduct Notification and Agreement

I have read and understand all parts of the KISD Athletic Student/ Parent Manual and have retained a copy for my records. As a Katy Independent School District Student-Athlete and Parent, we will abide by stated policies and rules.

Student _____ Parent _____ Date: _____
Signature _____ Signature _____

Parent and Student Notification/Agreement Form

Illegal Steroid Use

- Texas state law prohibits possessing, dispensing, delivering or administering a steroid in a manner not allowed by state law.
- Texas state law also provides that body building, muscle enhancement or the increase in muscle bulk or strength through the use of a steroid by a person who is in good health is not a valid medical purpose.
- Texas state law requires that only a medical doctor may prescribe a steroid for a person.
- Any violation of state law concerning steroids is a criminal offense punishable by confinement in jail or imprisonment in the Texas Department of Criminal Justice.

HEALTH CONSEQUENCES ASSOCIATED WITH ANABOLIC STEROID ABUSE (source: National Institute on Drug Abuse)

- *In boys and men*, reduced sperm production, shrinking of the testicles, impotence, difficulty or pain in urinating, baldness, and irreversible breast enlargement (gynecomastia).
- *In girls and women*, development of more masculine characteristics, such as decreased breast size, deepening of the voice, excessive growth of body hair, and loss of scalp hair.
- *In adolescents of both sexes*, premature termination of the adolescent growth spurt, so that for the rest of their lives, abusers remain shorter than they would have been without the drugs.
- *In males and females of all ages*, potentially fatal liver cysts and liver cancer; blood clotting, cholesterol changes, and hypertension, each of which can promote heart attack and stroke; and acne. Although not all scientists agree, some interpret available evidence to show that anabolic steroid abuse-particularly in high doses-promotes aggression that can manifest itself as fighting, physical and sexual abuse, armed robbery, and property crimes such as burglary and vandalism. Upon stopping anabolic steroids, some abusers may experience symptoms of depressed mood, fatigue, restlessness, loss of appetite, insomnia, headache, muscle and joint pain, and the desire to take more anabolic steroids.
- *In injectors*, infections resulting from the use of shared needles or non-sterile equipment, including HIV/AIDS, hepatitis B and C, and infective endocarditis, a potentially fatal inflammation of the inner lining of the heart. Bacterial infections can develop at the injection site, causing pain and abscess.

Student Certification

I have read the above information and agree that a prerequisite of my participation in UIL athletic activities is that I refrain from illegal steroid use. As a prerequisite to participation, I agree that I will not use illegal steroids. I understand that failure to provide accurate and truthful information could subject me to penalties as determined by UIL.

Student Signature _____ Date _____

Parent/Guardian Certification

I have read the above information and acknowledge that a prerequisite of my student's participation in UIL athletic activities is that they refrain from illegal steroid use. I understand that failure to provide accurate and truthful information could subject the participant in question to penalties as determined by UIL.

Parent/Guardian Signature _____ Date _____

Print Athlete Name

School

Grade

A
T
H

S
T
E

Personal Student Information for Athletics

Student name: Last	First	MI
Address: Street	City	State Zip
D.O.B.	Age	Grade
S.S.# _____ / ____ / _____	Home Phone: () _____ - _____	

Father's Name: Last	First	MI
Father's Home Address (if different): Street		
City	State	Zip
Father Employed By:		Email Address:
Father's Hm Phone: () _____ - _____	Wk Phone: () _____ - _____	
Cell Phone: () _____ - _____	S.S.# _____ / ____ / _____	

Mother's Name: Last	First	MI
Mother's Home Address (if different): Street		
City	State	Zip
Mother's Employed By:		Email Address:
Mother's Hm Phone: () _____ - _____	Wk Phone: () _____ - _____	
Cell Phone: () _____ - _____	S.S.# _____ / ____ / _____	

Insurance Information

Insured Name: Last	First	MI
Insurance Company:		
Group No.:	Certificate or Policy No.:	
Insurance Company Address:		
City	State	Zip
Insurance Type: <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare		

ACKNOWLEDGEMENT OF RULES

Attention School Authorities: This form must be signed yearly by both the student and parent/guardian and be on file at your school before the student may participate in any practice session, scrimmage, or contest. A copy of the student's medical history and physical examination form signed by a physician or medical history form signed by a parent must also be on file at your school.

Student's Name _____ Date of Birth _____

Current School _____

Parent or Guardian's Permit

I hereby give my consent for the above student to compete in University Interscholastic League approved sports, and travel with the coach or other representative of the school on any trips.

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 high school assumes any responsibility in case an accident occurs.

I have read and understand the University Interscholastic League rules on the reverse side of this form and agree that my son/daughter will abide by all of the University Interscholastic League rules.

The undersigned agrees to be responsible for the safe return of all athletic equipment issued by the school to the above named student.

If, in the judgement of any representatives of the school, the above student needs 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 to said student by any physician, athletic trainer, nurse, hospital, or school representative; and I do hereby agree to indemnify and save harmless the school and any school representative from any claim by any person whomsoever on account of such care and treatment of said student.

I have been provided the UIL Parent Information Manual regarding health and safety issues and my responsibilities as a parent/guardian. I understand that failure to provide accurate and truthful information on UIL forms could subject the student in question to penalties determined by the UIL.

Your signature below gives authorization that is necessary for the school district, its trainers, coaches, associated physicians and student insurance personnel to share information concerning medical diagnosis and treatment for your student.

- | | | | | | |
|---|--|-----------------------------------|--|--|------------------------------------|
| To the Parent: | <input type="checkbox"/> Baseball | <input type="checkbox"/> Football | <input type="checkbox"/> Softball | <input type="checkbox"/> Tennis | <input type="checkbox"/> Wrestling |
| Check any activity in which this | <input type="checkbox"/> Basketball | <input type="checkbox"/> Golf | <input type="checkbox"/> Swimming & Diving | <input type="checkbox"/> Track & Field | |
| student is allowed to participate. | <input type="checkbox"/> Cross Country | <input type="checkbox"/> Soccer | <input type="checkbox"/> Team Tennis | <input type="checkbox"/> Volleyball | |

Date _____

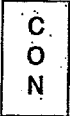
Signature of parent or guardian _____

Street address _____

City/State/Zip _____

Home area code and telephone _____

Business telephone _____



The student's signature is required on the reverse side of this form.

PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

REVISED 11-3-06

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: _____ 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, 5, 7, 11, or 16 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. 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>4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Have you ever passed out during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever been dizzy 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, hypertrophic cardiomyopathy, long QT syndrome, 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>6. 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>7. 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>8. Have you ever become ill from exercising in the heat? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Have you ever gotten unexpectedly short of breath with exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you cough, wheeze, or have trouble breathing during or after activity? <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>10. Have you had any problems with your eyes or vision? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Are you missing any paired organs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. 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>13. 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>14. 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>15. Do you feel stressed out? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16. Are you under a doctor's care? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Females Only</p> <p>17. 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 five 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; padding: 5px; min-height: 50px;"> <p>_____</p> <p>_____</p> <p>_____</p> </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 high 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: _____

PREPARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAMINATION

Student's Name _____ Sex _____ Age _____ Date of Birth _____
 Height _____ Weight _____ % Body fat (optional) _____ Pulse _____ BP ____/____ (____/____, ____/____)
 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			
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.

EM CARD

Katy Independent School District
Parent Authorization to Consent to Treatment of Student

(I) (We) the undersigned parent(s) of (print students name) _____, a minor, do hereby authorize the Katy Independent School District staff as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any licensed physician/surgeon, whether such diagnosis or treatment is rendered at the office of said physician/surgeon or at a hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which aforementioned physician/surgeon in the exercise of his/her best judgment may deem advisable. (I) (We) hereby authorize any hospital which has provided treatment to the above-named minor to surrender physical custody of such minor to my/our above-named agent(s) upon completion of treatment.

These authorizations shall remain effective until _____ (year) _____

Date

Parent/Legal Guardian

Parent/Legal Guardian

STATE OF TEXAS, County _____

Before me the undersigned authority, on this day personally appeared _____ the person(s) whose name(s) is/are subscribed to the fore going instrument, and acknowledge to me that he/she/they executed the same for the purposes and considerations therein expressed.

Given under my hand and seal of office on the _____ day of _____, _____ (year) Notary Public in and for _____ County, Texas. My commission expires _____.

Notary Signature

Printed/Stamped Name of Notary

Father's Name _____
Work Phone _____ Home Phone _____ Cell Phone _____

Mother's Name _____
Work Phone _____ Home Phone _____ Cell Phone _____

Insurance Company: HMO PPO Medicaid Medicare

Emergency Contact Name _____ Phone _____