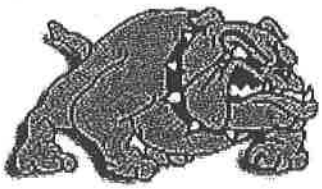

Fall River Junior-Senior High School
***More than 100 Years of* PRIDE**
PO Box 340
44215 Walnut Street
McArthur, California 96056
PHONE # (530) 336-5515 FAX # (530) 336-6256

Dear Athletes and Parents/Guardians:

There are **two** parts in this packet that must be completed and turned into the office before you are allowed to participate in practice.

Physicals: (blue) Physicals may be completed at any health care facility.

Mountain Valleys Health Center will be offering physicals for **$27. Athletes must have a parent signature on the blue physical form before the exam.** Payment must be made at the time of the appointment. You must call to schedule an appointment. (Do this sooner than later, because appointments fill up at the end of summer). **If you are covered under *Partnership*, please indicate so when calling to make your appointment.**

Insurance and Release Form: (pink)
Athletes must provide all insurance information listed on the pink form.
Insurance may be purchased through Myers-Stevens Co. (Applications available in the office).

Please call the office if you have any questions. Have a great summer and get ready for another great year of athletics here in Bulldog Country!

Kelly Freeland-Sloat
Athletic Director
kfreelandsloat@frjusd.org

FALL RIVER JOINT UNIFIED SCHOOL DISTRICT

NOTE: STUDENTS ARE NOT TO ENGAGE IN ANY PRACTICES OR GAMES UNTIL ALL PARTS OF THIS FORM ARE COMPLETED AND TURNED IN THE OFFICE.

Student's Name ______________________________ **Today's Date** ______________

Athletic Insurance Information

Fall River Joint Unified School District requires every member of any interscholastic athletic team, as well as those associated directly with any interscholastic athletic even, including song and cheerleaders, team mascots, team managers, etc. to possess accidental bodily insurance providing at least $5,000 of scheduled medical and hospital benefits. **Please specify on the form below the required insurance coverage that you have provided for your child.**

I have purchased accident insurance through the Myers – Stevens & Toohey & Co., Inc. (available at the school office) as shown below (check appropriate response):

_______ Tackle football insurance (covers tackle football only)
_______ School time insurance (covers sports other than football)
_______ Full time insurance (covers sports other than football)

OR

_______ I have health or accident insurance for my child that meets the requirements of California law and elect not to purchase student insurance through Myers – Stevens & Toohey & Co., Inc. (list the company name and group or policy number). (Pit River Health is not considered an insurance provider)

______________________________ ______________________________
Company Name and claim office address — Group or Policy Number

______________________________ ______________________________
Parent/Guardian Signature — Date

****

EMERGENCY INFORMATION

Student's Date of Birth __________ Home Phone __________ Emergency Phone __________

Parent/Guardian ______________________ (Father) ______________________ (Mother)

Phone: Father __________ Mother __________
Cell __________ Cell __________
Work __________ Work __________

Person to contact if parents cannot be reached:

Name ______________________ Phone ______________________

Student's Physician ______________________ Phone ______________________

Does this student have any injury or physical condition that should be watched? _____ Yes _____ No

If **Yes**, please explain: ____

****

INJURY WARNING & PARENTAL PERMISSION TO PARTICIPATE IN ATHLETICS AND TO BE TREATED IN CASE OF INJURY

Participation in competitive athletics may result in severe injury, including and not limited to sprains, strains, fractured bones, unconsciousness, head and/or back injuries, loss of eyesight, communicable diseases, paralysis and death. Changes in rules, improved conditioning programs, better medical coverage, and improvements in equipment have reduced these risks, but it is impossible to totally eliminate such occurrences from athletics. Players can reduce the chance of injury by obeying all safety rules in their sport, reporting all physical problems to their coaches, following a proper conditioning program, and inspecting their own equipment daily. ***Damaged equipment must be replaced immediately.*** Even if all these requirements are met, and even if the athlete is using excellent protective equipment,

serious accidents may still occur. I understand and acknowledge that in order to participate in these activities, I and my son/daughter agree to assume liability and responsibility for any and all potential risks which may be associated with participation in these activities. I understand, acknowledge, and agree that the District, its employees, officers, agents and/or volunteers, shall not be liable for any injury/illness suffered by my son/daughter which is incident to and/or associated with preparing for and/or participating in this activity. I hereby give my consent for my son/daughter to compete in interscholastic athletics in the FRJUSD and go with a representative of the school on any athletic trips. I understand that the FRJUSD will not provide medical services, hospital services, or accident insurance. If my son/daughter is injured, school district personnel are authorized to have him/her treated. I certify that he/she has insurance coverage, which meets the requirements of the District.

WE ACKNOWLEDGE THAT WE HAVE READ AND UNDERSTAND THIS WARNING STATEMENT AND PARTICIPATION AGREEMENT AND AGREE TO ITS TERMS.

Parent/Guardian Signature _____ Date _____

Student Athlete Signature _____ Date _____

FOOTBALL ONLY – HELMET WARNING ACKNOWLEDGEMENT

WARNING – Do not strike an opponent with any part of the helmet or facemask. This is a violation of football rules and may cause you to suffer severe brain or neck injury, including paralysis or death. NO HELMET CAN PREVENT ALL SUCH INJURIES. YOU USE THIS HELMET AT YOUR OWN RISK.

We have read and understand this warning notice.

Player Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

GENERAL AUTHORIZATION FORM (E5131.61)

I understand that my performance as a participant and the reputation of my school are dependent, in part, on my conduct as an individual. I hereby agree to accept and abide by the standards, rules, and regulations set forth by the Fall River Joint Unified School District Board of Trustees for the activity in which I participate.

I also authorize the FRJUSD to conduct a test on a specimen that I provide to test for drugs and/or alcohol use. I also authorize the release of information concerning the results of such a test to the Superintendent or designee and to my parents and/or guardians.

INCLUDING AUTHORIZATION FORM (ED. CODE 49030, E5131.63, AND CIF BYLAW 200.D)

I understand and acknowledge receipt of the 'Agreement for Student Athlete and Parent/Guardian Regarding Use of Steroids' included in the Student Activities Handbook. I hereby agree to accept and abide by the standards, rules, and regulations set forth in the Fall River Joint Unified School District Board of Trustees policy for the activity in which I participate.

Player Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

STUDENT ACTIVITIES HANDBOOK ACKNOWLEDGEMENT

I have read and understand the Policy Statement, the Code of Ethics, and the violations, minimum penalties, and Appeal Process of the NSCIF "Ethics in Sports" Policy that are included in the Fall River Joint Unified School District's **Student Activities Handbook**. I agree to abide by these policies while participating in NSCIF athletics regardless of contest site or jurisdiction.

Player Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

FALL RIVER JOINT UNIFIED SCHOOL DISTRICT

Preparticipation Physical Evaluation

HISTORY

DATE OF EXAM _____

Name _____ Sex _____ Age _____ Date of birth _____

Grade ____ School _____ Sport(s) _____

Address _____ Phone _____

Personal physician _____

In case of emergency, contact

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

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

	Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?	☐	☐
Do you have an ongoing or chronic illness?	☐	☐
2. Have you ever been hospitalized overnight?	☐	☐
Have you ever had surgery?	☐	☐
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	☐	☐
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	☐	☐
4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	☐	☐
Have you ever had a rash or hives develop during or after exercise?	☐	☐
5. Have you ever passed out during or after exercise?	☐	☐
Have you ever been dizzy during or after exercise?	☐	☐
Have you ever had chest pain during or after exercise?	☐	☐
Do you get tired more quickly than your friends do during exercise?	☐	☐
Have you ever had racing of your heart or skipped heartbeats?	☐	☐
Have you had high blood pressure or high cholesterol?	☐	☐
Have you ever been told you have a heart murmur?	☐	☐
Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	☐	☐
Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	☐	☐
7. Have you ever had a head injury or concussion?	☐	☐
Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐
Have you ever had a seizure?	☐	☐
Do you have frequent or severe headaches?	☐	☐
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	☐	☐
Have you ever had a stinger, burner, or pinched nerve?	☐	☐
8. Have you ever become ill from exercising in the heat?	☐	☐
9. Do you cough, wheeze, or have trouble breathing during or after activity?	☐	☐
Do you have asthma?	☐	☐
Do you have seasonal allergies that require medical treatment?	☐	☐

	Yes	No
10. 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)?	☐	☐
11. Have you had any problems with your eyes or vision?	☐	☐
Do you wear glasses, contacts, or protective eyewear?	☐	☐
12. Have you ever had a sprain, strain, or swelling after injury?	☐	☐
Have you broken or fractured any bones or dislocated any joints?	☐	☐
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	☐	☐

If yes, check appropriate box and explain below.

☐ Head	☐ Elbow	☐ Hip
☐ Neck	☐ Forearm	☐ Thigh
☐ Back	☐ Wrist	☐ Knee
☐ Chest	☐ Hand	☐ Shin/calf
☐ Shoulder	☐ Finger	☐ Ankle
☐ Upper arm		☐ Foot

13. Do you want to weigh more or less than you do now?	☐	☐
Do you lose weight regularly to meet weight requirements for your sport?	☐	☐
14. Do you feel stressed out?	☐	☐

15. Record the dates of your most recent immunizations (shots) for:

Tetanus _____ Measles _____

Hepatitis B _____ Chickenpox _____

FEMALES ONLY

16. 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? _____

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 _____

FALL RIVER JOINT UNIFIED SCHOOL DISTRICT

Preparticipation Physical Evaluation

PHYSICAL EXAMINATION

Name _____ Date of birth _____

Height _____ Weight _____ % Body fat (optional) _____ Pulse _____ BP ___/___ (___/___ , ___/___)

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

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
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: _____

_____

_____

_____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO