

Student Name: \_\_\_\_\_

Grade: \_\_\_\_\_ Sport(s): \_\_\_\_\_

School Year: 2017-18

## Athletic Participation Checklist

\_\_\_\_\_ Pre-Participation Physical Evaluation (2 pages)

\_\_\_\_\_ Concussion Acknowledgement

\_\_\_\_\_ Late Pick Up Policy

\_\_\_\_\_ Parental Authorization and Release

\_\_\_\_\_ SCA Awareness Form

\_\_\_\_\_ Steroid Agreement

\_\_\_\_\_ Transportation Form

\_\_\_\_\_ Participation Fee Form

\_\_\_\_\_ \$200 Athletic Fee – per sport, per student - Check, cash or money order

**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 Uplift North Hills Preparatory

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**

	Yes	No		Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you ever gotten unexpectedly short of breath with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been hospitalized overnight in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	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"/>	<input type="checkbox"/>
Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever had a sprain, strain, or swelling after injury?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have you broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, check appropriate box and explain below.		
Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip
Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh
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"/>	<input type="checkbox"/>	<input type="checkbox"/> Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Knee
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Shin/Calf
Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger	<input type="checkbox"/> Ankle
4. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Foot	
Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you want to weigh more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how many times? _____			Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
When was the last concussion? _____			17. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
How severe was each one? (Explain below)			18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Females Only</b>		
Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	19. When was your first menstrual period?		_____
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	<input type="checkbox"/>	<input type="checkbox"/>	When was your most recent menstrual period?		_____
Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	How much time do you usually have from the start of one period to the start of another?		_____
5. Are you missing any paired organs?	<input type="checkbox"/>	<input type="checkbox"/>	How many periods have you had in the last year?		_____
6. Are you under a doctor's care?	<input type="checkbox"/>	<input type="checkbox"/>	What was the longest time between periods in the last year?		_____
7. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	<b>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.</b>		
8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>**EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary):</b>		
9. Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
11. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
12. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>	_____		

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*
<b>MEDICAL</b>			
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)			

<b>MUSCULOSKELETAL</b>			
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.

**Uplift North Hills Preparatory  
Transportation Form 2017-18**

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**PLEASE PRINT**

Name: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Emergency Contact Number: \_\_\_\_\_

My son/daughter may ride with the following UNHP parent/family:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have agreed upon the appropriate means of transportation for my Uplift North Hills Preparatory athlete. We agree to abide by this agreement for the 2017-18 school year. Any changes must be made in written form and given to Athletic Director KraTaura Buckner & the coach of your student's individual sport **before** the date of transport.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date



# University Interscholastic League



## Parent and Student Agreement/Acknowledgement Form Anabolic Steroid Use and Random Steroid Testing

- 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 licensed practitioner with prescriptive authority 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.

### STUDENT ACKNOWLEDGEMENT AND AGREEMENT

As a prerequisite to participation in UIL athletic activities, I agree that I will not use anabolic steroids as defined in the UIL Anabolic Steroid Testing Program Protocol. I have read this form and understand that I may be asked to submit to testing for the presence of anabolic steroids in my body, and I do hereby agree to submit to such testing and analysis by a certified laboratory. I further understand and agree that the results of the steroid testing may be provided to certain individuals in my high school as specified in the UIL Anabolic Steroid Testing Program Protocol which is available on the UIL website at [www.uiltexas.org](http://www.uiltexas.org). I understand and agree that the results of steroid testing will be held confidential to the extent required by law. I understand that failure to provide accurate and truthful information could subject me to penalties as determined by UIL.

Student Name (Print): \_\_\_\_\_ Grade (9-12) \_\_\_\_\_

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### PARENT/GUARDIAN CERTIFICATION AND ACKNOWLEDGEMENT

As a prerequisite to participation by my student in UIL athletic activities, I certify and acknowledge that I have read this form and understand that my student must refrain from anabolic steroid use and may be asked to submit to testing for the presence of anabolic steroids in his/her body. I do hereby agree to submit my child to such testing and analysis by a certified laboratory. I further understand and agree that the results of the steroid testing may be provided to certain individuals in my student's high school as specified in the UIL Anabolic Steroid Testing Program Protocol which is available on the UIL website at [www.uiltexas.org](http://www.uiltexas.org). I understand and agree that the results of steroid testing will be held confidential to the extent required by law. I understand that failure to provide accurate and truthful information could subject my student to penalties as determined by UIL.

Name (Print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to student: \_\_\_\_\_



## SUDDEN CARDIAC ARREST AWARENESS FORM

Revised June 2013

Name of Student: \_\_\_\_\_

### What is Sudden Cardiac Arrest?

- Occurs suddenly and often without warning.
- An electrical malfunction (short-circuit) causes the bottom chambers of the heart (ventricles) to beat dangerously fast (ventricular tachycardia or fibrillation) and disrupts the pumping ability of the heart.
- The heart cannot pump blood to the brain, lungs and other organs of the body.
- The person loses consciousness (passes out) and has no pulse.
- Death occurs within minutes if not treated immediately.

### What causes Sudden Cardiac Arrest?

- **Conditions present at birth**
  - ***Inherited (passed on from parents/relatives) conditions of the heart muscle:***
    - ◆ **Hypertrophic Cardiomyopathy** – hypertrophy (thickening) of the left ventricle; the most common cause of sudden cardiac arrest in athletes in the U.S.
    - ◆ **Arrhythmogenic Right Ventricular Cardiomyopathy** – replacement of part of the right ventricle by fat and scar; the most common cause of sudden cardiac arrest in Italy.
    - ◆ **Marfan Syndrome** – a disorder of the structure of blood vessels that makes them prone to rupture; often associated with very long arms and unusually flexible joints.
  - ***Inherited conditions of the electrical system:***
    - ◆ **Long QT Syndrome** – abnormality in the ion channels (electrical system) of the heart.
    - ◆ **Catecholaminergic Polymorphic Ventricular Tachycardia and Brugada Syndrome** – other types of electrical abnormalities that are rare but run in families.
  - ***NonInherited (not passed on from the family, but still present at birth) conditions:***
    - ◆ **Coronary Artery Abnormalities** – abnormality of the blood vessels that supply blood to the heart muscle. The second most common cause of sudden cardiac arrest in athletes in the U.S.
    - ◆ **Aortic valve abnormalities** – failure of the aortic valve (the valve between the heart and the aorta) to develop properly; usually causes a loud heart murmur.
    - ◆ **Non-compaction Cardiomyopathy** – a condition where the heart muscle does not develop normally.
    - ◆ **Wolff-Parkinson-White Syndrome** – an extra conducting fiber is present in the heart's electrical system and can increase the risk of arrhythmias.
- **Conditions not present at birth but acquired later in life:**
  - ◆ **Commotio Cordis** – concussion of the heart that can occur from being hit in the chest by a ball, puck, or fist.
  - ◆ **Myocarditis** – infection/inflammation of the heart, usually caused by a virus.
  - ◆ **Recreational/Performance-Enhancing drug use.**
- **Idiopathic:** Sometimes the underlying cause of the Sudden Cardiac Arrest is unknown, even after autopsy.



## SUDDEN CARDIAC ARREST AWARENESS FORM

Revised June 2013

### What are the symptoms/warning signs of Sudden Cardiac Arrest?

- Fainting/blackouts (especially during exercise)
- Dizziness
- Unusual fatigue/weakness
- Chest pain
- Shortness of breath
- Nausea/vomiting
- Palpitations (heart is beating unusually fast or skipping beats)
- Family history of sudden cardiac arrest at age < 50

**ANY of these symptoms/warning signs that occur while exercising may necessitate further evaluation from your physician before returning to practice or a game.**

### What is the treatment for Sudden Cardiac Arrest?

- Time is critical and an immediate response is vital.
- **CALL 911**
- **Begin CPR**
- **Use an Automated External Defibrillator (AED)**

### What are ways to screen for Sudden Cardiac Arrest?

- The American Heart Association recommends a pre-participation history and physical including 12 important cardiac elements.
- **The UIL *Pre-Participation Physical Evaluation - Medical History* form includes ALL 12 of these important cardiac elements and is mandatory annually.**
- Additional screening using an electrocardiogram and/or an echocardiogram is readily available to all athletes, but is not mandatory.

### Where can one find information on additional screening?

- American Heart Association ([www.heart.org](http://www.heart.org))
- August Heart ([www.augustheart.org](http://www.augustheart.org))
- Championship Hearts Foundation ([www.championshipheartsfoundation.org](http://www.championshipheartsfoundation.org))
- Cypress ECG Project ([www.cypressecgproject.org](http://www.cypressecgproject.org))
- Parent Heart Watch ([www.parentheartwatch.com](http://www.parentheartwatch.com))

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Name (Print)

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student Name (Print)

# Uplift Education

## Parental Authorization and Release Form

THIS FORM MUST BE COMPLETED, SIGNED BY PARENT/GUARDIAN, NOTARIZED, AND RETURNED TO THE APPROPRIATE ATHLETIC DIRECTOR/COACH/EVENT SPONSOR.

Student/Athlete \_\_\_\_\_ Grade \_\_\_\_\_

I, \_\_\_\_\_ of \_\_\_\_\_  
(Parent/Guardian Name) (Street Address)

City of \_\_\_\_\_, \_\_\_\_\_ (County) Texas, am the \_\_\_\_\_ of

\_\_\_\_\_, a minor, who is enrolled in Uplift North Hills Preparatory  
(student's name) (Name of School)

located at 606 E. Royal Lane, Irving, TX 75039  
(School Address)

I desire said child to go on any and all field trips and participate in any and all extracurricular activities with other children from Uplift North Hills Preparatory (Name of School), during the academic school year 2017-18. In consideration of said student being permitted to make such trips and take part in such activities and instruction, I hereby release Uplift North Hills Preparatory (Name of School) its directors, teachers, employees, together with any volunteer carriers of such child without compensation, from any and all liability and responsibility in connection with such trip and activities, and hereby release all said parties from all liability by reason accident or injury suffered by said child while on said trips or engaged in such activities. I authorize said school and its representatives to consent to medical treatment for my child in case of any illness or injury in connection with a clinic or hospital as, may be selected by the school, or its representative. The school is not financially responsible for the emergency care or transportation.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

Notarized Date: \_\_\_\_\_

SUBSCRIBED AND SWORN TO before me by said affiant on this day, to certify which witness my hand and seal of office this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

My commission expires: \_\_\_\_\_

Notary Public in and for the county of Dallas, Texas.



# Uplift Education

## Parental Authorization and Release Form

***NOTE TO PARENTS:*** Consent to Release forms are taken by teachers and coaches to all activities off campus, including athletic and wilderness events. Past experience indicates that the following information is most helpful when responding to medical emergencies and seeking immediate treatment in emergency rooms.

Emergency telephone numbers of parents/guardians:

Father Home: \_\_\_\_\_ Mother Home: \_\_\_\_\_  
Work: \_\_\_\_\_ Work: \_\_\_\_\_  
Cell: \_\_\_\_\_ Cell: \_\_\_\_\_

Emergency telephone number of close friend or relative if parent(s) cannot be reached:

Name: \_\_\_\_\_ Home: \_\_\_\_\_  
Work: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Cell: \_\_\_\_\_

Preferred Local Physician: \_\_\_\_\_ Office Telephone: \_\_\_\_\_

If it is necessary to transport your child to a local emergency room or trauma center, please list the hospital of choice: \_\_\_\_\_

Group Insurance or Health Plan: \_\_\_\_\_

Customer Service Telephone Number: \_\_\_\_\_

Policy and Group Number: \_\_\_\_\_

## **Athlete Pick Up**

Athletes must be picked up immediately at the end of practice. Coaches of that sport will supervise scholars for up to 15 minutes after the conclusion of the practice. Athletes not picked up by this time will be required to pay a fee of \$10 fee. The \$10 fee is applied at sixteen minutes past the conclusion of practice and will be applied again every fifteen minutes after. This fee will help cover the cost of the coach's time for having to stay and wait with that athlete.

If you have a specific situation where you might be more than fifteen minutes late picking- up your athlete (multiple sports, multiple practice sites, parent/teacher conference, etc.), please be sure you communicate this with the coach ahead of time and work out a prior arrangement.

Records of late pickups will be recorded in a log that all coaches will have access to at each site. The coach will be responsible for notifying the parent that they were more than fifteen minutes past the scheduled conclusion of practice, and when possible acquire the parent/guardians signature in the log. If there is no notification from the coach at the time of the incident, the fee will not be applied.

Thank you in advance for your compliance with this policy.

Athlete Signature \_\_\_\_\_

Parent Signature \_\_\_\_\_



# CONCUSSION ACKNOWLEDGEMENT FORM

Name of Student \_\_\_\_\_

**Definition of Concussion** - means a complex pathophysiological process affecting the brain caused by a traumatic physical force or impact to the head or body, which may: (A) include temporary or prolonged altered brain function resulting in physical, cognitive, or emotional symptoms or altered sleep patterns; and (B) involve loss of consciousness.

**Prevention** - Teach and practice safe play & proper technique.

- Follow the rules of play.
- Make sure the required protective equipment is worn for all practices and games.
- Protective equipment must fit properly and be inspected on a regular basis.

**Signs and Symptoms of Concussion** - The signs and symptoms of concussion may include but are not limited to: Head ache, appears to be dazed or stunned, tinnitus (ringing in the ears), fatigue, slurred speech, nausea or vomiting, dizziness, loss of balance, blurry vision, sensitive to light or noise, feel foggy or groggy, memory loss, or confusion.

**Oversight** - Each district shall appoint and approve a Concussion Oversight Team (COT). The COT shall include at least one physician and an athletic trainer if one is employed by the school district. Other members may include: Advanced Practice Nurse, neuropsychologist or a physician's assistant. The COT is charged with developing the Return to Play protocol based on peer reviewed scientific evidence.

**Treatment of Concussion** - The student-athlete shall be removed from practice or competition immediately if suspected to have sustained a concussion. Every student-athlete suspected of sustaining a concussion shall be seen by a physician before they may return to athletic participation. The treatment for concussion is cognitive rest. Students should limit external stimulation such as watching television, playing video games, sending text messages, use of computer, and bright lights. When all signs and symptoms of concussion have cleared and the student has received written clearance from a physician, the student-athlete may begin their district's Return to Play protocol as determined by the Concussion Oversight Team.

**Return to Play** - According to the Texas Education Code, Section 38.157:

A student removed from an interscholastic athletics practice or competition under Section 38.156 may not be permitted to practice or compete again following the force or impact believed to have caused the concussion until:

- (1) the student has been evaluated, using established medical protocols based on peer-reviewed scientific evidence, by a treating physician chosen by the student or the student's parent or guardian or another person with legal authority to make medical decisions for the student;
- (2) the student has successfully completed each requirement of the return-to-play protocol established under Section 38.153 necessary for the student to return to play;
- (3) the treating physician has provided a written statement indicating that, in the physician's professional judgment, it is safe for the student to return to play; and
- (4) the student and the student's parent or guardian or another person with legal authority to make medical decisions for the student:
  - (A) have acknowledged that the student has completed the requirements of the return-to-play protocol necessary for the student to return to play;
  - (B) have provided the treating physician's written statement under Subdivision (3) to the person responsible for compliance with the return-to-play protocol under Subsection (c) and the person who has supervisory responsibilities under Subsection (c); and
  - (C) have signed a consent form indicating that the person signing:
    - (i) has been informed concerning and consents to the student participating in returning to play in accordance with the return-to-play protocol;
    - (ii) understands the risks associated with the student returning to play and will comply with any ongoing requirements in the return-to-play protocol;
    - (iii) consents to the disclosure to appropriate persons, consistent with the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191), of the treating physician's written statement under Subdivision (3) and, if any, the return-to-play recommendations of the treating physician; and
    - (iv) understands the immunity provisions under Section 38.159.

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

## **UPLIFT NORTH HILLS PREPARATORY ATHLETIC PARTICIPATION FEE**

### **POLICY & GUIDELINES**

All sports require a flat fee of \$200 to subsidize the cost for transportation, supplies, rented venues, equipment, and tournaments. The fee for any sport must be paid prior to the first official game or meet.

#### **Middle School Fees (grades 6<sup>th</sup>, 7<sup>th</sup>, & 8<sup>th</sup>)**

1. \$200 fee for each sport listed below
  - a. Volleyball
  - b. Cross Country
  - c. Swimming
  - d. Basketball
  - e. Soccer
  - f. Track & Field
2. Students will be charged for all sports during the school year.

#### **High School Fees (grades 9-12)**

1. \$200 fee for each sport listed below.
  - a. Volleyball
  - b. Cross Country
  - c. Swimming
  - d. Basketball
  - e. Golf
  - f. Tennis
  - g. Soccer
  - h. Track & Field
2. Students will be charged for all sports during the school year.

#### **Waiver Policy**

1. Students that have submitted application and been approved for the Free & Reduced Lunch Program by the Food & Nutrition Department qualify and may request reduced participation fee.
2. Students on Free & Reduced Lunch status will be charged at 50% of the normal participation fee.
3. Students on Free & Reduced Lunch unable to pay at the 50% rate level may submit an **ATHLETIC PARTICIPATION FEE WAIVER – SCHOOL/COMMUNITY SERVICE REQUEST** to the athletic director.

4. School Administration will review the Waiver Request with student to determine a plan of action to assist the student to compensate for any fee reduction and/or fee elimination.
5. UNHP will do all it can to legally provide support necessary so that all students can participate.

### **Refund Policy**

1. If a student is injured or ill and cannot complete the remainder of the season, **based on a note provided by a licensed physician**, prior to the midpoint of the season, a 50% refund will be granted, if requested. If the injury or illness occurs after the midpoint of the season, no refund will be granted.
2. Students are eligible, upon request, for a full refund if they quit the team for any reason during the first five days of the season.
3. Any student who quits a team after the fifth day of will not be eligible for a refund.
4. Any student who is removed from the team due to inappropriate behavior, violation of the Athletic Code of Conduct, Scholar Code of Conduct, and or academic ineligibility will not be eligible for a refund.

### **Information Applicable to All Students**

1. Participation Fees do not guarantee a spot on an athletic team, playing time, or a letter award.
2. Students will not be allowed to tryout if there is an existing participation fee balance from participation in a previous sport season.
3. Participation Fees should be paid prior to the first day of a game or meet for the respective sport season. Athletes are not allowed to practice if fee is not paid prior to the Monday of the second week of tryouts.
4. Players are considered ineligible if fee is not paid prior to first contest. Contest forfeiture may be imposed for use of such ineligible player.

I have received and read a copy of the 2017-18 UNHP Athletic Participation Fee Form. I understand the form contains information that I may need during the school year and that I am responsible for adhering to the policies, procedures and practices discussed within the form.

**Print Student Name** \_\_\_\_\_

**Date** \_\_\_\_\_

**Student Signature** \_\_\_\_\_

**Print Parent Name** \_\_\_\_\_

**Date** \_\_\_\_\_

**Parent Signature** \_\_\_\_\_