Submit forms per instructions on AWMTB.com home page

6/21

TAMALPAIS UNION HIGH SCHOOL DISTRICT
MOUNTAIN-BIKING (MTB) CLUB PARTICIPATION CLEARANCE FORM

Parental Permission: I/we consent to the following:

A) ______________________________________ has my/our permission to participate in the following MTB club at this school.
(student name)
M F Circle   Grade Level _______   **Archie Williams High School Mountain Bike Club**

B) I/we permit the above named student to compete in MTB club-related events and travel to away competitions, including overnight.

C) If he/she is injured, the coach and/or school official is authorized to have him/her treated.

I understand and acknowledge that MTB club participation is a privilege granted to all students who voluntary accept the rules and regulations outlined and as such is not required by the District.

I understand and acknowledge that some of the injuries/illnesses which may result from participating in these activities include, but are not limited to, the following:

1. Sprains/strains
2. Fractured bones
3. Concussions
4. Head and/or back injury
5. Paralysis
6. Loss of eyesight
7. Communicable diseases
8. Death

I understand and acknowledge that in order to participate in these activities, I agree to assume liability and responsibility for any and all potential risks which may be associated with participation in such activities.

I understand, acknowledge, and agree that the District, its employees, officers, agents, or volunteers shall not be liable for any injury/illness suffered incidental to and/or associated with preparing for and/or participating in this activity.

I acknowledge that I have carefully read this **VOLUNTARY ACTIVITIES ACKNOWLEDGEMENT AND ASSUMPTION OF POTENTIAL RISK** information, all information provided is truthful and that I understand and agree to its terms.

1. Parent/Guardian Signature ____ Date ____________________
Address:____ e-mail: ____________________________
Street City Zip
Phone: Mother (h) _______________(w/c) ______________Father (h) _________________(w/c) _________________

- -

2. Medical issues of which the school/coach should be aware:

____

3. In case of injury/emergency (when parents/guardian are not available) notify:

Name/relationship ____Phone(s) ________________________

4. Insurance Certification: This certifies that the above named student is covered by personal accident insurance in case of injury while participating in interscholastic athletics during the coming school year. **Low cost school insurance is available, but may have limits that may not cover ambulance or other major medical expenses. Please read and understand such policy terms.**

Insurance Carrier ____Policy # ____________________________

5. Doctor's Certification: Please complete the attached medical clearance forms as follows:

1. **PRE-PARTICIPATION PHYSICAL EVALUATION: CLEARANCE FORM (completed by physician and returned to school club)**
2. **PRE-PARTICIPATION PHYSICAL EVALUATION: HISTORY FORM (completed by student/family and retained by physician in medical record)**
3. **PRE-PARTICIPATION PHYSICAL EVALUATION: PHYSICAL EXAMINATION FORM (completed by physician and retained in medical record)**

TAMALPAIS UNION HIGH SCHOOL DISTRICT - STUDENT CONTRACT

I WILL

- Show respect for myself, teammates, coach, opponents, and officials.
- Use no foul language, trash talk, negative gestures or actions to provoke a negative response or fighting.
- Avoid hazing of any description. Penalties may include, but are not limited to, removal from the team, suspension and/or criminal charges.

Acknowledged by:_____ _____ _____

Student Signature **Email** **Date**

CONDITIONS OF PARTICIPATION FOR STUDENTS:

By signing below, both the participating student and the parents, legal guardian/caregiver hereby agree that the student shall not use androgenic/anabolic steroids without the written prescription of a fully licensed physician (as recognized by the AMA) to treat a medical condition. We also understand that the Tamalpais Union High School District policy regarding the use of illegal drugs will be enforced for any violations of these rules.

TRANSPORTATION: BP 3541.1(a) and BP 3541.1(b) The Superintendent, or designee, will neither authorize nor arrange for the transportation of the students by private automobile. **Rather, students and/or their parents will be expected to assume responsibility and make their own arrangements for transportation to practices and contests. Coaches are never to provide transportation for students.**

_____ _____

Signature of Student **Date**

_____ _____

Signature of Parent/Caregiver **Date**

TAMALPAIS UNION HIGH SCHOOL DISTRCT

Concussion Information Form

A concussion is a brain injury and all brain injuries are serious. They are caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, **all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly.** In other words, even a "ding" or a bump on the head can be serious. You can't see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

Symptoms may include one or more of the following:

- Headaches
- "Pressure in head"
- Nausea or vomiting
- Neck pain
- Balance problems or dizziness
- Blurred, double, or fuzzy vision
- Sensitivity to light or noise
- Feeling sluggish or slowed down
- Feeling foggy or groggy
- Drowsiness
- Change in sleep patterns
- Amnesia
- "Don't feel right"
- Fatigue or low energy
- Sadness
- Nervousness or anxiety
- Irritability
- More emotional
- Confusion
- Concentration or memory problems (forgetting game plays)
- Repeating the same question/comment

Signs observed by teammates, parents and coaches include:

- Appears dazed
- Vacant facial expression
- Confused about assignment
- Forgets plays
- Is unsure of game, score, or opponent
- Moves clumsily or displays incoordination
- Answers questions slowly
- Slurred speech
- Shows behavior or personality changes
- Can't recall events prior to hit
- Can't recall events after hit
- Seizures or convulsions
- Any change in typical behavior or personality
- Loses consciousness

What can happen if my child keeps on playing with a concussion or returns to soon?

Athletes with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one. This can lead to prolonged recovery, or even to severe brain swelling (second impact syndrome) with devastating and even fatal consequences. It is well known that adolescent or teenage athlete will often under report symptoms of injuries. And concussions are no different. As a result, education of administrators, coaches, parents and students is the key for student-athlete's safety.

If you think your child has suffered a concussion

Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear, without medical clearance. Close observation of the athlete should continue for several hours. Current guidance now requires implementation of long and well-established return to play concussion guidelines that have been recommended for several years:

> "A student-athlete who is suspected of sustaining a concussion or head injury in a practice or game shall be removed from competition at that time and for the remainder of the day."
>
> **and**
>
> "A student-athlete who has been removed may not return to play until the athlete is evaluated by a licensed heath care provider trained in the evaluation and management of concussion and received written clearance to return to play from that health care provider".

You should also inform your child's coach if you think that your child may have a concussion Remember its better to miss one game than miss the whole season. And when in doubt, the athlete sits out.

For current and up-to-date information on concussions you can go to:
http://www.cdc.gov/ConcussionInYouthSports/

Adapted from the CDC and the 3rd International Conference on Concussion in Sport.
Document created 5/20/2010. Required by AB25 effective Nov. 2011.

PRE-PARTICIPATION PHYSICAL EVALUATION:
MTB CLUB CLEARANCE FORM (TO BE SIGNED BY PHYSICIAN AND RETURNED TO MTB CLUB)

Name_____ **□ Male □ Female Age**_____ **Date of Birth** _____

CLEARANCE

□ **Cleared for all Mountain-biking Club activities without restriction**

□ **Cleared for all Mountain-biking Club activities without restriction with recommendation for further evaluation or treatment for:**

_____

□ **Not cleared □ Pending further evaluation**
□ For certain MTB activities_____**Reason**_____

Recommendations:

_____
_____
_____
_____
_____

I have examined the above-named student and completed the pre-participation physical evaluation for mountain-biking. The student does not present apparent clinical contraindications to practice and participate. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the student has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the student and his/her parents/guardian.

Name of physician (print/type) _____MD or DO

Signature_____Date of Examination_____

Address _____ Phone _____

EMERGENCY INFORMATION

ALLERGIES:

_____
_____
_____
_____

OTHER INFORMATION:

_____
_____
_____
_____
_____
_____

6/21

MTB CLUB PRE-PARTICIPATION PHYSICAL EVALUATION: HISTORY FORM (TO BE RETAINED BY PHYSICIAN)

(This form is to be filled out by the parent/patient prior to seeing the physician. The physician should keep this it in the medical chart.)

Name_____ Date of Exam _____ School_____

Gender_____ Date of Birth_____ Grade_____

Medicines and Allergies: Please list all the prescriptions and over-the-counter medicines and supplements (herbal and medicinal) that you are currently taking:

_

_____ _____

Do you have any allergies? □ Yes □ No If yes, please identify the specific allergy(ies):

□ Pollens _____ □ Food _____ □ Medicines _____ □ Insects_____ □ Other

_____

Explain 'yes' answers on the back of this page. Circle questions you don't know the answer to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? Identify: □ Asthma □ Anemia □ Diabetes □ Infection □Other:_____		
3. Have you ever spent the night in a hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: □ High blood pressure □ A heart murmur □ High cholesterol □ A heart infection □ Kawasaki disease □ Other		
9. Has a doctor ever ordered a test for your heart? (i.e. EKG/ECG, echocardiogram)		
10. Do you get light-headed or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)?		
14. Does anyone in your family have hypertropic cardiomyopathy, Marfan syndrome, anthythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures or near drowning?		
BONE AND JOINT QUESTIONS	Yes	No
17. Have you ever had an injury to a bone, muscle, ligament or tendon that caused you to miss a practice or game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoxial instability, Down syndrome or dwarfism?		
22. Do you regularly use a brace, orthotics or other assistive device?		
23. Do you have a bone/muscle/joint injury bothering you?		
24. Do any of your joints become painful, swollen, feel warm or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		
MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze or have difficulty breathing during or af ter exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen or any other organ?		
30. Do you have groin pain or painful bulge/hernia in the groin?		
31. Have you had infectious mononucleosis (mono) in the last month?		
32. Do you have any rashes, pressure sores or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps while exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear such as goggles or face shield?		
47. Do you worry about your weight?		
48. Are you trying or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Are you currently using any prescription or over-the-counter medications?		
52. Do you drink alcohol?		
53. Do you smoke or vape with plain or nicotine/marijuana laced juices?		
54. Have you every used any illegal drugs including marijuana, opiods or other?		
55. Have you ever taken anabolic steroids or used any other supplement to gain or lose weight or improve performance?		
56. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY	Yes	No
57. Have you ever had a menstrual period?		
58. How old were you when you had your first menstrual period?		
59. How many periods have you had in the last 12 months?		

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of student_____ Signature of parent_____ Date_____ ©

MOUNTAIN-BIKING CLUB PRE-PARTICIPATION PHYSICAL EVALUATION:
PHYSICAL EXAMINATION FORM (TO BE RETAINED BY PHYSICIAN)

Name _____ Date of exam_____

PHYSICIAN REMINDERS (This form should be kept in the medical records)

1. **Consider additional questions on more sensitive issues.**
   - **Do you feel stressed out or under a lot of pressure?**
   - **Do you ever feel sad, hopeless, depressed or anxious?**
   - **Do you feel safe at your home or residence?**
   - **Have you ever tried vaping, cigarettes, chewing tobacco, snuff or dip?**
   - **During the past 30 days, have you vaped or used cigarettes, chewing tobacco, snuff or dip?**
   - **Do you drink alcohol or use any other drugs?**
   - **Have you ever taken anabolic steroids or used any other performance supplement?**
   - **Have you ever taken any supplements to help you gain orlose weight or improve your performance?**
   - **Do you always wear a seat belt, use a helmet and use condoms.**

2. **Consider reviewing questions on cardiovascular symptoms (questions 5-14)**

EXAMINATION		
Height Weight □ Male □ Female Date of birth:		
BP / (/) Pulse Vision: R 20/ L 20/ Corrected? □ Yes □ No		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance: Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/Ears/Nose/Throat: Pupils equal, Hearing		
Lymph nodes		
Heart[1]: Murmurs (auscultation standing, supine, ± Valsalva) Location of point of maximal impulse (PMI)		
Pulses: Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[2]		
Skin: HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[3]		
MUSCULAR/SKELETAL		
Neck		
Back		
Shoulder/Arms		
Elbow/Forearm		
Wrist/Hands/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		
Functional: Duck-walk, single leg hop		

[1]Consider ECG, echocardiogram and referral to cardiology for abnormal cardiac history or exam
[2]Consider GU exam if in a private setting. Having a third party present is recommended.
[3]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion

□ **Cleared for all Mountain-biking Club activities without restriction**
□ **Cleared for all Mountain-biking Club without restriction with recommendation for further for further evaluation or treatment for**_____

_____

□ **Not cleared** □ **Pending further evaluation_**
□ **For any Mountain-biking Club**
□ **For certain Mountain-biking Club: Reason:**

_____

Recommendations _ _____

I have examined the above-named student and completed the pre-participation physical evaluation. The student does not present apparent clinical contraindications to practice and participate in the Mountain-biking Club activities as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete and his/her parents/guardian.

Name of physician (print/type) _____ Signature_____MD/DO

Address _____Phone_____Date_____