



AGREEMENT FOR TEAM PARTICIPATION

[Including Waivers and Releases of Potential Claims]

This Agreement must be signed and returned to the School Office before a Student can participate in Team Activities. Each Team must be listed below. If not listed, a separate Participation Agreement will be required.

Additional Required Forms – Concussion and Head Injury Information Sheet & Sports Physical Examination Form

Student:	Address:
Grade:	DOB:
School:	Telephone:
Team(s):	

In consideration of the Student’s ability to participate on a Team [including any Sport, Cheerleading, Dance, or Marching Band], including try-outs, practices, pre-season or seasonal strength or training sessions or training camps, or actual participation in Team events, shows, performances, or competitions, or the traveling to or from any of these activities (“Team Activities”), the Student and Parent/Legal Guardian (“Adult”) signing this Agreement agree as follows:

1. It is a privilege, not a right, to participate in extra-curricular activities, including Team Activities. The privilege may be revoked at any time, for any reason that does not violate Federal or State law or District policies or procedures. There is no guarantee that the Student will make a Team, remain on a Team, or actively participate in Team events, shows, performances, or competitions. Such matters shall remain exclusively within the judgment and discretion of the supervising District employee or volunteer coach.
2. The Student and the Adult understand the nature of the Team, including the inherent or potential risks of Team Activities. The Student is in sufficiently good health and physical condition to participate in Team Activities, and voluntarily wishes to participate in Team Activities. Before participating in any Team Activity, a properly executed Sports Physical Examination Form and Concussion Head Injury Sheet shall be submitted to the school office (valid for one academic year, Fall/Winter/Spring Activities).
3. The Student shall comply with the instruction and directions of Team Activity teachers, coaches, supervisors, chaperones, and instructors. During the Student’s participation in Team Activities, as well as academic and/or other school activities, the Student shall comply with all applicable Codes of Conduct. The Student shall also generally conduct himself/herself at all times in keeping with the highest moral and ethical standards so as to reflect positively on himself/herself, the Team and the District. Failure to meet these obligations may, in the discretion of the District, result in removal from the Team and/or Team Activities. Should the Student’s violation of these obligations result in bodily injury or property damage, the Adult agrees to (a) pay to restore or replace the damaged property, (b) pay for bodily injury damages to an individual, and (c) defend, protect and hold the District harmless from such claims.
4. Team Activities contain potential risks of harm or injury, including harm or injury that may lead to permanent or serious physical injury to the Student, including paralysis, brain injury, or death (“Injuries”). Injuries might arise from the Student’s actions or inactions, the actions or inactions of another Student or participant in a Team Activity, or the actual or alleged failure by District employees, agents or volunteers to adequately coach, train, instruct, or supervise Team Activities. Injuries might also arise from an actual or alleged failure to properly maintain, use, repair, or replace physical facilities or equipment available for Team Activities. Injuries might also arise from undiagnosed, improperly diagnosed,

untreated, improperly treated, or untimely treated actual or potential physical conditions or Injuries, whether or not caused by or related to the Student's participation in Team Activities. All such risks are deemed to be inherent to the Student's participation in Team Activities. To the fullest extent allowed by law, the Student and Adult therefore also fully assume all such risks and waive and release any potential future claim they might otherwise have been able to assert against the District and any Board Member, employee, agent, or volunteer of the District ("Released Parties"), including any claim that could otherwise have been made on behalf of the Student or any parent, administrator, executor, trustee, guardian, assignee or family member. The Student and Adult further understand that Team Activities and transportation to and/or from Team Activities are "field trips" for which there is immunity from liability pursuant to Education Code Section 35330.

5. If the Student believes that an unsafe condition or circumstance exists, or otherwise feels or believes that continued participation in a Team Activity might present a risk of Injury, the Student will immediately discontinue further participation in the Team Activity, notify School personnel of the Student's belief, and notify a parent or guardian of the Student's belief. The parent or guardian shall thereafter prevent the Student from participating in the Team Activity until the unsafe condition or circumstance is addressed or remedied to their satisfaction.

6. Emergency medical information regarding the Student is on file with the District and is current. The Adult agrees to provide updated medical information during the course of the Student's participation in Team Activities. If an injury or medical emergency occurs during Team Activities, District employees, agents or volunteers have my express permission to administer or to authorize the administration of urgent or emergency care, including the transportation of the Student to an urgent care or emergency care provider. In such circumstances, notice to me and/or the Emergency Contact of the injury or medical emergency may be delayed. Therefore, any urgent or emergency care provider has my express authority to conduct diagnostic or anesthetic procedures, and/or to provide medical care or treatment (including surgery), as they may deem reasonable or necessary under all existing circumstances. All costs and expenses associated with such care are solely my responsibility. An Adult can only withhold this authorization by filing an Objection to Medical Care (Education 49407) that is based on their personally held religious beliefs.

7. Education Code Section 32221.5 requires us to notify you that: Under state law, school districts are required to ensure that all members of school athletic teams have accidental injury insurance that covers medical and hospital expenses. This insurance requirement can be met by the school district offering insurance or other health benefits that cover medical and hospital expenses. Some pupils may qualify to enroll in no-cost or low-cost local, state, or federally sponsored health insurance programs. Information about these programs may be obtained by calling the District at (916) 566-1646. Education Code Section 32221 requires that such insurance cover medical and hospital expenses resulting from bodily injuries in one of the following amounts: (a) a group or individual medical plan with accident benefits of at least \$200 for each occurrence and major medical coverage of at least \$10,000, with no more than \$100 deductible and no less than 80% payable for each occurrence; (b) group or individual medical plans which are certified by the Insurance Commissioner to be equivalent to the required coverage of at least \$1,500; or (c) at least \$1,500 for all such medical and hospital expenses. You may meet this obligation in one of two ways:

Option 1: Private medical insurance/Medical. If this option is selected, please provide _____ (Name of Insurer/Provider) and _____ (Policy number/Identifying number), _____ (list coverage dates or "continuous"). The Adult agrees that the Student is covered, and will remain covered during the length of the Team season and that coverage exists in the amounts required by Section 32221.

Option 2: Purchase insurance meeting the requirements of Section 32221, for the period during which the Student is participating on the Team, through a coverage provider made available through the District [please contact the District to gain additional information regarding this program]. If you are financially unable to pay for such insurance, and, if no other alternate funding is available through private or charitable organizations, the District will obtain financing for the required coverage.

8. Employees, agents or volunteers of the District, members of the press or media, or other persons who may attend or participate in Team Activities, may photograph, videotape, or take statements from the Student. Such photographs, videotapes, recordings, or written statements may be published or reproduced in a manner showing the Student's name, face, likeness, voice, thoughts, beliefs, or appearance to third parties, including, without limitation, webcasts, television, motion pictures, films, newspapers, yearbooks, and magazines. Such published or reproduced items, whether or not for a profit, may be used for security, training, advertising, news, publicity, promotional, informational, or any other lawful

purpose. We authorize and consent to any such publications or reproductions, without compensation, and without reservation or limitation.

9. This Agreement is to be broadly construed to enforce the purposes and agreements set forth above, and shall not be construed against the Released Parties solely on the basis that this Agreement was drafted by the District. If any part of this Agreement is deemed invalid or ineffective, all other provisions shall remain in force. No oral modification of this Agreement, or alleged change or modification of its terms by subsequent conduct or oral statement, is allowed. This Agreement contains the sole and exclusive understanding of the parties, with no other representation relied upon by the Adult or Student in determining whether to execute this Agreement or in agreeing to participate in Team Activities.

AS THE ADULT SIGNING BELOW: (1) I AM GIVING UP SUBSTANTIAL ACTUAL OR POTENTIAL RIGHTS IN ORDER TO ALLOW THE STUDENT TO PARTICIPATE IN TEAM ACTIVITIES; (2) I HAVE SIGNED THIS AGREEMENT WITHOUT ANY INDUCEMENT OR ASSURANCE OF ANY NATURE, AND WITH FULL APPRECIATION OF THE RISKS INHERENT IN TEAM ACTIVITIES; (3) I HAVE NO QUESTION REGARDING THE SCOPE OR INTENT OF THIS AGREEMENT; (4) I, AS A PARENT OR LEGAL GUARDIAN, HAVE THE RIGHT AND AUTHORITY TO ENTER INTO THIS AGREEMENT, AND TO BIND MYSELF, THE STUDENT, AND ANY AND ANY OTHER FAMILY MEMBER, PERSONAL REPRESENTATIVE, ASSIGN, HEIR, TRUSTEE, OR GUARDIAN TO THE TERMS OF THIS AGREEMENT AND I HAVE EXPLAINED THIS AGREEMENT TO THE STUDENT, WHO UNDERSTANDS HIS/HER OBLIGATIONS.

Printed Name of Parent/Guardian	Signature	Date
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As the Student, I understand and agree to all of obligations placed on me by this Agreement.

Printed Name of Student	Signature	Date
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CONCUSSION AND HEAD INJURY INFORMATION SHEET

Student:		Address:	
Grade:		Telephone:	
School:	School Year:	DOB:	

Pursuant to Education Code Section 49475, before a Student may try-out, practice, or compete in any District-sponsored extracurricular athletic program, including interscholastic, intramural, or other sport or recreation programs (including cheer/dance teams and marching band), but excluding physical education courses for credit, the student and parent/legal guardian must review and execute this Concussion and Head Injury Information Sheet. Once signed, the Sheet is good for one academic year (Fall through Spring) and is applicable to all athletic programs in which the Student may participate.

IMPORTANT INFORMATION REGARDING CONCUSSIONS

If a Student is suspected of sustaining a concussion or head injury during an athletic activity, the Student shall be immediately removed from the activity. The Student will not be allowed to resume any participation in the activity until he/she has been evaluated by a licensed health care provider (MD or DO for CIF-governed interscholastic sports; MD, DO, nurse practitioner, or physician’s assistant for all other sports/athletic activities), who must affirmatively state (1) that he/she has been trained in concussion management and is acting within the scope of his/her licensed medical practice, and (2) the student has been personally evaluated by the health care provider and has received a full medical clearance to resume participation in the activity. By law, there can be no exceptions to this medical clearance requirement.

Depending on the circumstances of a particular practice or game, a supervising referee/umpire, coach/assistant coach, athletic trainer, or attending health care provider may determine that a student should be removed from an activity based on a suspected or potential concussion or head injury. The following guidelines will be used: (1) in the case of an actual or perceived loss of consciousness, the student must be immediately removed from the activity; (2) in all other cases, standardized concussion assessment tools (e.g., Sideline Concussion Assessment Tool (SCAT-II), Standardized Assessment of Concussion (SAC), or Balance Error Scoring System (BESS) protocol) will be used as the basis to determine whether the student should be removed from the activity. For the safety and protection of the student, once a supervising individual makes a determination that a student must be withdrawn from activity due to the potential existence of a concussion or head injury, no other coach, player, parent or other involved individual may overrule this determination.

Once a student is removed from an activity, the parent/guardian should promptly seek a medical evaluation by a licensed health care provider, even if the student does not immediately describe or show physical symptoms of a concussion (headache, pressure in the head, neck pain, nausea or vomiting, dizziness, blurred vision, balance problems, sensitivity to light or sound, feeling “slow,” “foggy,” or “not right,” difficulty with concentration or memory, confusion, drowsiness, irritability or emotionality, anxiety or nervousness, or difficulty falling asleep).

If the student reports or shows any of these symptoms, immediate medical health care should be obtained. If a parent or legal guardian is not immediately available to make health care decisions, the District reserves the right to have the student taken for emergency or urgent evaluation or medical care in keeping with the authorization contained in the Agreement for Team Participation.

Dated: _____ Dated: _____

Student _____ Adult _____

Signature _____ Signature _____



CONCUSSION AND HEAD INJURY [AND SERIOUS INJURY] REPORT FORM

Student:	School:
Grade:	Sport:
Date of Incident:	Coach:

Concussions and Head Injuries

On _____, the Student listed above was involved in the following incident

that may have resulted in him/her suffering a concussion or head injury. As a result, the Student was immediately withdrawn from further participation in the listed Sport and will not be allowed to return to practice or participation until a satisfactory medical clearance is provided to the District, which must be provided on the Medical Clearance Form contained on the back of this form.

We urge you to seek prompt medical review and attention, particularly if the Student shows any signs of a concussion or head injury (including headache, pressure in the head, neck pain, nausea or vomiting, dizziness, blurred vision, balance problems, sensitivity to light or sound, feeling “slow,” “foggy,” or “not right,” difficulty with concentration or memory, confusion, drowsiness, irritability or emotionality, anxiety or nervousness, or difficulty falling asleep).

Other Serious Injuries [For Optional District Use/Recommended but not Legally Required]

On _____, the Student listed above was involved in the following incident

that resulted in an injury considered serious by one or more of the supervising adults. As a result, the Student was immediately withdrawn from further participation in the listed Sport and will not be allowed to return to practice or participation until a satisfactory medical clearance is provided to the District, which must be provided on the Medical Clearance Form contained on the back of this form..

We urge you to seek prompt medical review and attention by a medical care provider trained to manage this type of injury.

Dated: _____

Printed Named of Coach/Supervising Adult: _____

Signature _____

CONCUSSION AND HEAD INJURY [AND SERIOUS INJURY] MEDICAL CLEARANCE FORM

PART 1 (COMPLETED BY A PARENT OR LEGAL GUARDIAN)			
LAST NAME	FIRST NAME		
BIRTHDATE	STUDENT ID NUMBER		
<p>1. Date of last complete physical examination: _____ Performing Physician/Regular Physician: _____</p> <p>2. Has the Student been seen by any health care provided on an emergency or urgent basis in the last 12-months? ___No ___Yes</p> <p>3. Has the Student suffered headaches, pressure in the head, neck pain, nausea or vomiting, dizziness, blurred vision, balance problems, sensitivity to light or sound, feeling “slow,” “foggy,” or “not right,” difficulty with concentration or memory, confusion, drowsiness, irritability or emotionality, anxiety or nervousness, or difficulty falling asleep). ___No ___Yes</p> <p>4. Has the Student suffered from any other symptom, condition, or injury that has, or might, impact his/her ability to safely participate in sports? ___No ___Yes</p> <p>5. Are you aware of any reason why the Student cannot presently participate safely in athletic training or activity and/or should not receive a full medical clearance to return to athletic activity ? ___No ___Yes</p> <p><i>Explain all “YES” answers, also describing any other fact that should be disclosed prior to the examination):</i></p> 			
<p>PARENT/GUARDIAN’S AUTHORIZATION: I authorize the health care provider to perform a Concussion and Head Injury [and Serious Injury] Medical Clearance Evaluation. I must provide an appropriately executed medical clearance to the District before the Student can potentially return to athletic practice or participation. The information above is true and correct to the best of my knowledge.</p>			
<small>PRINT NAME OF PARENT OR GUARDIAN</small>	<small>SIGNATURE OF PARENT OR GUARDIAN</small>		
<small>ADDRESS</small>	<small>WORK PHONE</small>	<small>HOME PHONE</small>	
<p>PART 2 – MEDICAL EVALUATION (COMPLETED BY THE EXAMINING HEALTH CARE PROVIDER)</p> <p>By law, post-concussion/head injury releases must be conducted by a MD/DO, who must represent on the release that they (1) have completed the required concussion training and (2) regularly practice in this medical specialty. <i>Ed. Code Section 49475.</i></p> <p>By signing this Form, the MD/DO represents that they comply with this law.</p> <p style="text-align: center;">MDs, Dos, P.A.s and N.P.’s may perform Serious Injury Medical Release Evaluations</p>			
	Normal	Abnormal (Describe)	
General Evaluation: Eyes/Ears/Nose/Throat/Skin/ Heart, Lungs, Pulmonary Function/ Abdomen/ Musculoskeletal			<p style="text-align: center;"><u>Release Determination</u></p> <p><input type="checkbox"/> Unlimited participation</p> <p><input type="checkbox"/> Limited participation/specific sports, events or activities (Describe in Comments Section)</p> <p><input type="checkbox"/> Clearance withheld pending further testing/evaluation</p> <p><input type="checkbox"/> No athletic participation</p> <p>One of the above MUST be checked.</p>
Neurologic Screening Exam (NSE)			
Concussion/Head Injury Evaluation			
Comments:			
<small>PRINT NAME OF PHYSICIAN</small>			



TWIN RIVERS UNIFIED SCHOOL DISTRICT SPORTS PHYSICAL EXAMINATION FORM

PART 1 (TO BE COMPLETED BY A PARENT OR LEGAL GUARDIAN)

LAST NAME		FIRST NAME			GRADE
BIRTHDATE	FALL SPORT	WINTER SPORT	SPRING SPORT	STUDENT ID NUMBER	

PART 1 -- HEALTH HISTORY (Must be Completed by Parent/Guardian Prior to the Examination)

	Yes	No	Has this student had:		Yes	No	
1.	<input type="checkbox"/>	<input type="checkbox"/>	Chronic or recurrent illness?	16.	<input type="checkbox"/>	<input type="checkbox"/>	Injuries requiring medical care or treatment?
2.	<input type="checkbox"/>	<input type="checkbox"/>	Illness lasting over 1 week?	17.	<input type="checkbox"/>	<input type="checkbox"/>	Neck or back pain or injury?
3.	<input type="checkbox"/>	<input type="checkbox"/>	Hospitalizations or Surgeries?	18.	<input type="checkbox"/>	<input type="checkbox"/>	Knee pain or injury?
4.	<input type="checkbox"/>	<input type="checkbox"/>	Nervous, psychiatric, or neurologic condition?	19.	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder or elbow pain or injury?
5.	<input type="checkbox"/>	<input type="checkbox"/>	Loss or nonfunctioning of organs (eye, kidney, liver, testicle) or glands?	20.	<input type="checkbox"/>	<input type="checkbox"/>	Ankle pain or injury?
6.	<input type="checkbox"/>	<input type="checkbox"/>	Allergies (medicines, insect bites, food)?	21.	<input type="checkbox"/>	<input type="checkbox"/>	Other joint pain or injury?
7.	<input type="checkbox"/>	<input type="checkbox"/>	Problems with heart or blood pressure?	22.	<input type="checkbox"/>	<input type="checkbox"/>	Broken bones (fractures)?
8.	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain or significant or severe shortness of breath during or after exercise?	23.	<input type="checkbox"/>	<input type="checkbox"/>	Does this student presently:
				24.	<input type="checkbox"/>	<input type="checkbox"/>	Wear eyeglasses or contact lenses?
					<input type="checkbox"/>	<input type="checkbox"/>	Wear dental bridges, braces or plates?
9.	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness or fainting with exercise?	25.	<input type="checkbox"/>	<input type="checkbox"/>	Take any medications? (List below):
10.	<input type="checkbox"/>	<input type="checkbox"/>	Fainting, bad headaches or convulsions?		<input type="checkbox"/>	<input type="checkbox"/>	Further history:
11.	<input type="checkbox"/>	<input type="checkbox"/>	Potential concussion or loss of consciousness?	26.	<input type="checkbox"/>	<input type="checkbox"/>	Birth defects (corrected or not)?
12.	<input type="checkbox"/>	<input type="checkbox"/>	Heat exhaustion, heatstroke, or other problems managing or responding to heat?	27.	<input type="checkbox"/>	<input type="checkbox"/>	Death of a parent or grandparent less than 40 years of age due to medical cause or condition?
13.	<input type="checkbox"/>	<input type="checkbox"/>	Racing heartbeat, skipped or irregular heartbeats, or heart murmur?	28.	<input type="checkbox"/>	<input type="checkbox"/>	Parent or grandparent requiring treatment for heart condition less than 50 years of age?
14.	<input type="checkbox"/>	<input type="checkbox"/>	Seizures or seizure disorders?	29.	<input type="checkbox"/>	<input type="checkbox"/>	Been seen by a physician on an emergency or urgent basis in the last 12-months?
15.	<input type="checkbox"/>	<input type="checkbox"/>	Severe or repeated instances of muscle cramps?				

Date of last known tetanus (lockjaw) shot: _____ Date of last complete physical examination: _____

Explain all "YES" answers. Describe any other fact that should be disclosed prior to the examination (use reverse of form if needed):

PARENT/GUARDIAN'S AUTHORIZATION: I authorize the health care provider to perform a Sports Physical Evaluation on the student. The information set forth above is complete and accurate. I presently know of no reason why the student cannot fully and safely participate in the listed sports. For Sports Physical Evaluations that may be performed by District volunteers, I understand the evaluation is a screening evaluation only, and that I must address all health care concerns with the Student's personal physician or health care provider.

PRINT NAME OF PARENT OR GUARDIAN		SIGNATURE OF PARENT OR GUARDIAN		
ADDRESS		WORK PHONE	HOME PHONE	DATE
REGULAR PHYSICIAN'S NAME		OFFICE PHONE		

PART 2 – MEDICAL EVALUATION (TO BE COMPLETED BY THE EXAMINING HEALTH CARE PROVIDER) This Evaluation Can Only be Performed by Medical Doctors (MDs), Doctors of Osteopathy (DOs), Physician's Assistants (P.A.s), and Nurse Practitioners (N.P.s)

	NORMAL	ABNORMAL (Describe)	(May be contained on Provider's Form)
Eyes/Ears/Nose/Throat			Height: Weight:
Heart, lungs, pulmonary function			Pulse: After Ex:
Abdomen, genital/hernia (males)			BP:
Skin and Musculoskeletal:			Recommendation: <input type="checkbox"/> Unlimited participation <input type="checkbox"/> Limited participation/specific sports, events or activities <input type="checkbox"/> Clearance withheld pending further testing/evaluation <input type="checkbox"/> No athletic participation One of the above MUST be checked.
a. Neck/Spine/Shoulders/Back			
b. Arms/Hands/Fingers			
c. Hips/Thighs/Knees/Legs			
d. Feet/Ankles			
Neurologic Screening Exam (NSE)/			
Concussion Screening Evaluation (only if needed based on above info.)			
Comments:			
PRINT NAME OF PHYSICIAN		PHYSICIAN'S SIGNATURE	DATE