Name: ______________ _____________ 7-8-9-10-11-12 2015-2016
Last First Circle Grade Year

***Please indicate what sport the athlete will participate in for the following seasons*:**

Fall Sport: ______________________
Winter Sport: ___________________
Spring Sport: ____________________

Important

• The checklist indicates the forms that require signatures by a **parent and/or student**
• **Only the forms on the list need to be turned in.**
• All forms must be **completed** and **turned in together with this page (cover page) attached**. Failure to do so will result in the packet being returned to you.

Forms that need to be turned in with this cover sheet:
_____ Emergency Medical Authorization (pg. 3)
_____ Pre-participation Physical Evaluation (pg. 5-6)
** Completed prior to having the physical taken*
_____ Physical Examination Form (pg. 7-8)
_____ OHSAA Authorization Form (pg. 9)
_____ OHSAA Eligibility and Authorization Statement (pg. 10)
_____ Insurance Verification and Information for Athletics (pg. 11)
_____ Insurance Verification and Information for Athletics at Other Facilities (pg. 12)
_____ Drug Free Athletics Parent Commitment (pg. 13)
_____ Athletic Code of Conduct signature page (pg. 17)

These forms are to be handed into your COACH or the Perry Athletic Office on or before the first day of practice.

Failure to do so will result in the athlete not being able to practice until all forms are completed and turned in.

☐ HEALTH ALERT

EMERGENCY MEDICAL AUTHORIZATION

PURPOSE - To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached. This information may be shared with the educational team to best meet your child's needs.

Student Name ______________________ Phone # ______________ **Bus #** __________

Address ______________________ School District ______________________

______________________ School Attending ______________________

Address Change Y N Birth Date ____________ Sex M F Grade ____ Home Room ______________

Residential Parent or Guardian

Mother______________ Day Ph # ______________ Cell/Pager #______________

Father ______________ Day Ph # ______________ Cell/Pager #______________

Other Name ______________ Day Ph # ______________ Cell /Pager#______________

Other Name ______________ Day Ph # ______________ Cell /Pager#______________

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor ______________________ Phone # ______________________

Dentist______________________ Phone # ______________________

Medical Specialist ______________________ Phone # ______________________

Hospital ______________________ Phone # ______________________

Below check any current health condition that may require attention during the school day:

- ☐ Allergies (be specific)
  - ☐ Foods ______________
  - ☐ Medicines ______________
  - ☐ Bee Stings ☐ EpiPen
  - ☐ Other ______________
- ☐ Asthma ☐ Inhaler
- ☐ Cancer
- ☐ Diabetes
- ☐ Hearing problems ☐ Hearing aid(s)
- ☐ Heart problems (be specific) ______________
- ☐ Surgeries (include year) ______________
- ☐ Concussion/head injury — year ______________
- ☐ Physical disability (be specific) ______________
- ☐ Respiratory (be specific) ______________
- ☐ Seizures ______________
- ☐ Vision problems (be specific) ______________
  - ☐ Glasses ☐ Contacts
- ☐ ADD/ADHD
- ☐ Behavior/emotional problems ______________
- ☐ Other (be specific) ______________

List all medications and dosages your child receives on a continual basis:

____

____

PLEASE COMPLETE PART I *OR* PART II — NOT BOTH

Part I — TO GRANT CONSENT

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by the designated physician or dentist, or in the event the designated practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to the designated hospital or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Date ______________ Parent or Guardian Signature ______________________

Part II — REFUSAL TO CONSENT

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to: ______________________

____

____

Date ______________ Parent or Guardian Signature ______________________

Revised 4/07

Section 3313.712, Ohio Revised Code

(Pursuant to H.B. 639)

(A) Annually, the board of education of each city, exempted village, local, and joint vocational school district shall, before the first day of October, have provided to the parent or legal guardian of every pupil enrolled in schools under the board's jurisdiction, an emergency medical authorization form that is an identical copy of the form contained in division (B) of this section. Thereafter, the board shall, within thirty days after the entry of any pupil into a public school in this state for the first time, provide the parent or legal guardian of such pupil, either as part of any registration form which is in use in the district, or as a separate form, an identical copy of the form contained in division (B) of this section.

When the form is returned to the school with Part I or Part II completed, the school shall keep the form on file, and shall send the form to any school of a city, exempted village, local, or joint vocational school district to which the pupil is transferred. Upon request of his parent or guardian, authorities of the school in which the pupil is enrolled may permit such parent or guardian to make changes in a previously filed form, or to file a new form.

If a parent or guardian does not wish to give such written permission, he shall indicate in the proper place on the form the procedure he wishes school authorities to follow in the event of a medical emergency involving a child.

Even if a parent or guardian gives written consent for emergency medical treatment, when a pupil becomes ill or is injured and requires emergency medical treatment while under school authority, or while engaged in an extracurricular activity authorized by the appropriate school authorities, the authorities of the school in which the pupil is enrolled shall make reasonable attempts to contact the parent or legal guardian before the treatment is given. The school shall present the pupil's emergency medical authorization form or a copy thereof to the hospital or practitioner rendering treatment.

Nothing in this section shall be construed to impose liability on any school official or school employee who, in good faith, attempts to comply with this section.

(B) The emergency medical authorization form provided for in division (A) of this section is as follows:
(See reverse side)

Ohio High School Athletic Association

PREPARTICIPATION PHYSICAL EVALUATION 2015-2016

HISTORY FORM – Please be advised that this paper form is no longer the OHSAA standard.

(Note: This form is to be filled out by the student and parent prior to seeing the medical examiner. The medical examiner should keep this form in the chart.)

Date of Exam ______________________________

Name ______________________________ Date of birth ______________

Sex ________ Age ________ Grade __________ School ______________________ Sport(s) ______________

Address ______________________________

Emergency Contact: ______________________________ Relationship ______________

Phone (H) ______________ (W) ______________ (Cell) ______________ (Email) ______________

Medicines and Allergies: Please list the prescription and over-the-counter medicines and supplements (herbal and nutritional-including energy drinks/ protein supplements) that you are currently taking

____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers 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? If so, please identify below: Asthma Anemia Diabetes Infections Other: ______________		
3. Have you ever spent the night in the 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? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded 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 hypertrophic cardiomyopathy, Marfan syndrome, arryhthmogenic 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 atlantoaxial instability? (Down syndrome or dwarfism)		

BONE AND JOINT QUESTIONS - CONTINUED	Yes	No
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swolllen, 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 after 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 a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the past month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes (cold sores) or MRSA (staph) 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 headaches, or memory problems?		
36. Do you have a history of seizure disorder or epilepsy?		
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 when 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 an eye injury?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to gain or lose weight? Has anyone recommended that you do?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

____

____

____

____

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

The student has family insurance ☐ Yes ☐ No If yes, family insurance company name and policy numbr ______________________________.

Signature of Student ______________________ Signature of parent/guardian ______________________ Date: ______________

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THE ATHLETE WITH SPECIAL NEEDS - SUPPLEMENTAL HISTORY FORM

PLEASE COMPLETE ONLY IF YOUR STUDENT HAS SPECIAL NEEDS OR A DISABILITY.

Date of Exam ____________________

Name ____________________ Date of birth ____________________ Sex ____________ Age __________ Grade __________ School ____________________ Sport(s) ____________________

		Yes	No
1.	Type of disability		
2.	Date of disability		
3.	Classification (if available)		
4.	Cause of disability (birth, disease, accident/trauma, other)		
5.	List the sports you are interested in playing		
		Yes	**No**
6.	Do you regularly use a brace, assistive device or prosthetic?		
7.	Do you use a special brace or assistive device for sports?		
8.	Do you have any rashes, pressure sores, or any other skin problems?		
9.	Do you have a hearing loss? Do you use a hearing aid?		
10.	Do you have a visual impairment?		
11.	Do you have any special devices for bowel or bladder function?		
12.	Do you have burning or discomfort when urinating?		
13.	Have you had autonomic dysreflexia?		
14.	Have you ever been diagnosed with a heat related (hyperthermia) or cold-related (hypothermia) illness?		
15.	Do you have muscle spasticity?		
16.	Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

____

____

____

____

Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

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 Student ____________________ Signature of parent/guardian ____________________ Date: ____________

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PHYSICAL EXAMINATION FORM

Name______________________________ Date of birth ______________

PHYSICIAN REMINDERS

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 cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use 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 or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet or use condoms?
   - Do you consume energy drinks?
2. Consider reviewing questions on cardiovascular symptoms (questions 5-14).

EXAMINATION	**DATE OF EXAMINATION** ______________	
Height Weight	☐ Male ☐ Female	
BP / (/) Pulse Vision R 20/ L20/	Corrected ☐ Y ☐ N	
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 Murmurs (auscultation standing, supine, +/- Valsalva) Location of the point of maximal impulse (PMI)		
Pulses Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional Duck walk, single leg hop		

[a]Consider ECG, echocardiogram, or referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third part present is recommended.
[c]Consider cognitive or baseline neuropsychiatric testing if a history of significant concussion.

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CLEARANCE FORM

Note: Authorization forms (pages 5 and 6) must be signed by both the parent/guardian and the student.

Name____________________ Sex ☐ M ☐ F Age________ Date of birth ____________

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ____________

☐ Not Cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports ____________
  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 sport(s) 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. In the event that the examination is conducted en masse at the school, the school administrator shall retain a copy of the PPE. 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 athlete (and parents/guardians).

Name of physician or medical examiner (print/type)____________ Date of Exam ________

Address____________ Phone ________

Signature of physician/medical examiner____________, MD, DO, D.C., P.A. or A.N.P.

EMERGENCY INFORMATION

Personal Physician____________ Phone ________

In case of Emergency, contact____________ Phone ________

Allergies____________

Other Information ____________

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THE STUDENT SHALL NOT BE CLEARED TO PARTICIPATE IN INTERSCHOLASTIC ATHLETICS UNTIL THIS FORM HAS BEEN SIGNED AND RETURNED TO THE SCHOOL

OHSAA AUTHORIZATION FORM 2015-2016

I hereby authorize the release and disclosure of the personal health information of_______________________________("Student"), as described below, to ________________________________("School").

The information described below may be released to the School principal or assistant principal, athletic director, coach, athletic trainer, physical education teacher, school nurse or other member of the School's administrative staff as necessary to evaluate the Student's eligibility to participate in school sponsored activities, including but not limited to interscholastic sports programs, physical education classes or other classroom activities.

Personal health information of the Student which may be released and disclosed includes records of physical examinations performed to determine the Student's eligibility to participate in school sponsored activities, including but not limited to the Pre-participation Evaluation form or other similar document required by the School prior to determining eligibility of the Student to participate in classroom or other School sponsored activities; records of the evaluation, diagnosis and treatment of injuries which the Student incurred while engaging in school sponsored activities, including but not limited to practice sessions, training and competition; and other records as necessary to determine the Student's physical fitness to participate in school sponsored activities.

The personal health information described above may be released or disclosed to the School by the Student's personal physician or physicians; a physician or other health care professional retained by the School to perform physical examinations to determine the Student's eligibility to participate in certain school sponsored activities or to provide treatment to students injured while participating in such activities, whether or not such physicians or other health care professionals are paid for their services or volunteer their time to the School; or any other EMT, hospital, physician or other health care professional who evaluates, diagnoses or treats an injury or other condition incurred by the student while participating in school sponsored activities.

I understand that the School has requested this authorization to release or disclose the personal health information described above to make certain decisions about the Student's health and ability to participate in certain school sponsored and classroom activities, and that the School is a not a health care provider or health plan covered by federal HIPAA privacy regulations, and the information described below may be redisclosed and may not continue to be protected by the federal HIPAA privacy regulations. I also understand that the School is covered under the federal regulations that govern the privacy of educational records, and that the personal health information disclosed under this authorization may be protected by those regulations.

I also understand that health care providers and health plans may not condition the provision of treatment or payment on the signing of this authorization; however, the Student's participation in certain school sponsored activities may be conditioned on the signing of this authorization.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by a health care provider in reliance on this authorization, by sending a written revocation to the school principal (or designee) whose name and address appears below.

Name of Principal: ____

School Address: ____

This authorization will expire when the student is no longer enrolled as a student at the school.

NOTE: IF THE STUDENT IS UNDER 18 YEARS OF AGE, THIS AUTHORIZATION MUST BE SIGNED BY A PARENT OR LEGAL GUARDIAN TO BE VALID. IF THE STUDENT IS 18 YEARS OF AGE OR OVER, THE STUDENT MUST SIGN THIS AUTHORIZATION PERSONALLY.

____

Student’s Signature Birth date of Student, including year

____

Name of Student's personal representative, if applicable

I am the Student's (check one): _______Parent_________Legal Guardian (documentation must be provided)

____

Signature of Student's personal representative, if applicable Date

A copy of this signed form has been provided to the student or his/her personal representative

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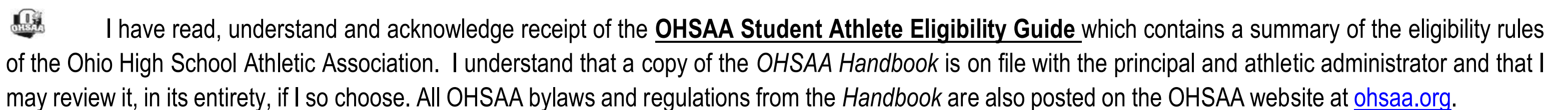
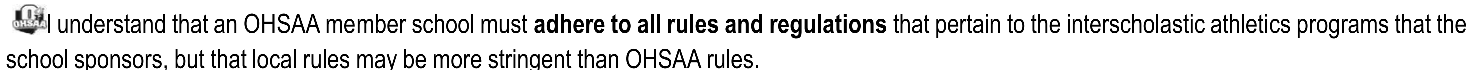
2015-2016 Ohio High School Athletic Association Eligibility and Authorization Statement

This document is to be signed by the participant from an OHSAA member school and by the participant's parent.


I have read, understand and acknowledge receipt of the **OHSAA Student Athlete Eligibility Guide** which contains a summary of the eligibility rules of the Ohio High School Athletic Association. I understand that a copy of the *OHSAA Handbook* is on file with the principal and athletic administrator and that I may review it, in its entirety, if I so choose. All OHSAA bylaws and regulations from the *Handbook* are also posted on the OHSAA website at ohsaa.org.


I understand that an OHSAA member school must **adhere to all rules and regulations** that pertain to the interscholastic athletics programs that the school sponsors, but that local rules may be more stringent than OHSAA rules.

I understand that participation in interscholastic athletics is a **privilege not a right**.

Student Code of Responsibility

As a student athlete, I **understand and accept** the following responsibilities:

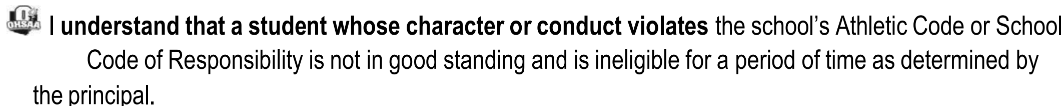
I will **respect the rights and beliefs** of others and will treat others with courtesy and consideration.

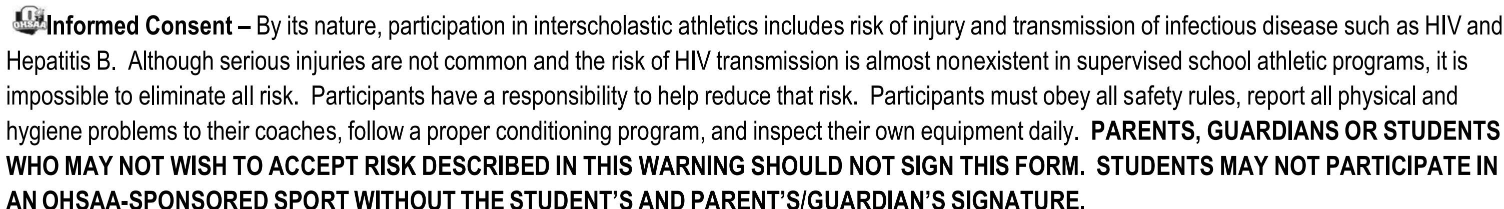
I will be **fully responsible** for my own actions and the consequences of my actions.

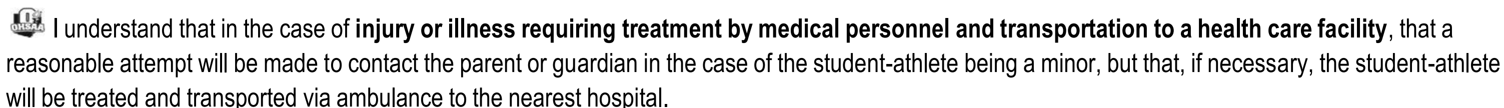
I will **respect the property** of others.

I will **respect and obey the rules** of my school and laws of my community, state and country.

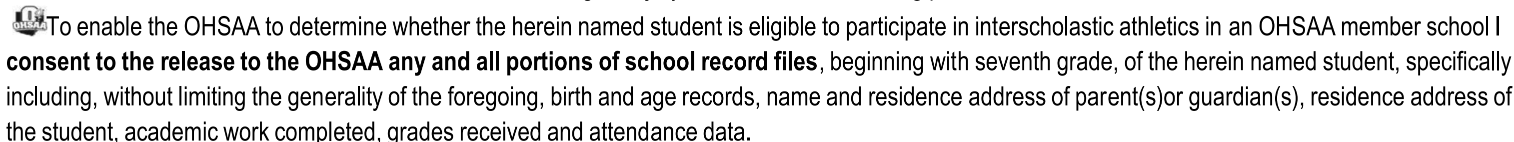
I will **show respect to those who are responsible for enforcing the rules** of my school and the laws of my community, state and country.


I **understand that a student whose character or conduct violates** the school's Athletic Code or School Code of Responsibility is not in good standing and is ineligible for a period of time as determined by the principal.

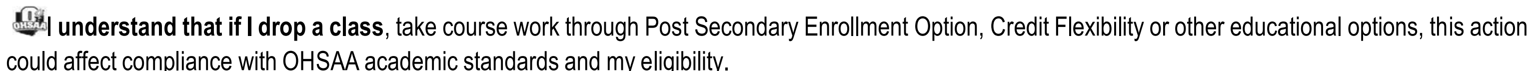

Informed Consent – By its nature, participation in interscholastic athletics includes risk of injury and transmission of infectious disease such as HIV and Hepatitis B. Although serious injuries are not common and the risk of HIV transmission is almost nonexistent in supervised school athletic programs, it is impossible to eliminate all risk. Participants have a responsibility to help reduce that risk. Participants must obey all safety rules, report all physical and hygiene problems to their coaches, follow a proper conditioning program, and inspect their own equipment daily. **PARENTS, GUARDIANS OR STUDENTS WHO MAY NOT WISH TO ACCEPT RISK DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS FORM. STUDENTS MAY NOT PARTICIPATE IN AN OHSAA-SPONSORED SPORT WITHOUT THE STUDENT'S AND PARENT'S/GUARDIAN'S SIGNATURE.**

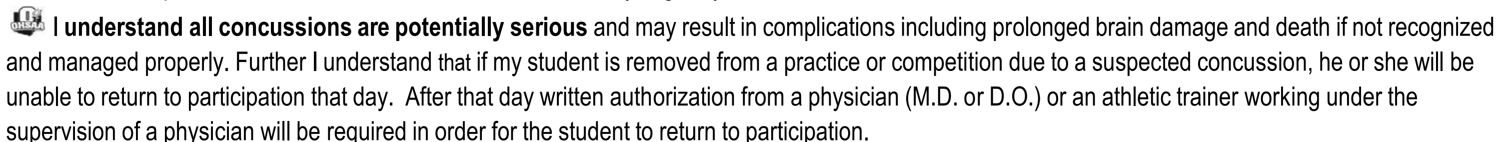

I understand that in the case of **injury or illness requiring treatment by medical personnel and transportation to a health care facility**, that a reasonable attempt will be made to contact the parent or guardian in the case of the student-athlete being a minor, but that, if necessary, the student-athlete will be treated and transported via ambulance to the nearest hospital.

I **consent to medical treatment** for the student following an injury or illness suffered during practice and/or a contest.


To enable the OHSAA to determine whether the herein named student is eligible to participate in interscholastic athletics in an OHSAA member school I **consent to the release to the OHSAA any and all portions of school record files**, beginning with seventh grade, of the herein named student, specifically including, without limiting the generality of the foregoing, birth and age records, name and residence address of parent(s)or guardian(s), residence address of the student, academic work completed, grades received and attendance data.

I consent to the OHSAA's use of the herein named student's name, likeness, and athletic-related information in reports of contests, promotional literature of the Association and other materials and releases related to interscholastic athletics.


I understand that if I drop a class, take course work through Post Secondary Enrollment Option, Credit Flexibility or other educational options, this action could affect compliance with OHSAA academic standards and my eligibility.


I understand all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly. Further I understand that if my student is removed from a practice or competition due to a suspected concussion, he or she will be unable to return to participation that day. After that day written authorization from a physician (M.D. or D.O.) or an athletic trainer working under the supervision of a physician will be required in order for the student to return to participation.

I have read and signed the Ohio Department of Health's **Concussion Information Sheet** and have retained a copy for myself.

By signing this we acknowledge that we have read the above information and that we consent to the herein named student's participation.

***Must Be Signed Before Physical Examination**

Student's Signature Birth date Grade in School Date

Parent's or Guardian's Signature Date

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PERRY LOCAL SCHOOL DISTRICT
INSURANCE VERIFICATION AND INFORMATION FOR ATHLETES
2015-2016

- I understand that Perry Local Schools does not carry insurance for athletic participation.
- I understand that Perry Local Schools is not responsible for payment of or reimbursement for medical expenses that are a result of participation in athletics.
- I assume all responsibility for medical expenses that are incurred as a result of my child's participation in all athletic events and practices.
- I may request information on insurance from the school my son or daughter attends by contacting the main office of that school or the athletic office.

The signature below indicates that I have read and understand all of the statements listed.

____

Parent's Name (Print)

____ _______________

Parent's Signature **Date**

____

Athlete's Name (Print)

PERRY LOCAL SCHOOL DISTRICT
INSURANCE VERIFICATION AND INFORMATION
FOR ATHLETES TO PARTICIPATE
AT OTHER FACILITIES
2015-2016

- Athletic Facilities that Perry Local Schools' athletes participtate at during competition and practices do not carry insurance for athletic participation.
- Athletic Facilities that Perry Local Schools' athletes participate at is not responsible for payment of or reimbursement for medical expenses that are a result of participation in athletics.
- Parents/Guardians assume all responsibility for medical expenses that are incurred as a result of their child's participation in all athletic events and practices.

The signature below indicates that I have read and understand all of the statements listed.

____
Parent's Name (Print)

____ _______________
Parent's Signature **Date**

____
Athlete's Name (Print)

PERRY HIGH SCHOOL
DRUG FREE ATHLETICS
PARENT COMMITMENT
2015-2016

As parent(s) of a student participating in the district athletic program, I/we will support our son's/daughter's agreement to abide by all the training rules involved in the district's athletic program.

To demonstrate my/our support, I pledge to:

Set a positive example by exhibiting either abstinence or responsible use of alcohol/drugs/tobacco.

1. Not serve alcohol or drugs to underage youth who are present in our home.

2. Notify the coach/athletic director of my son's/daughter's violation of the athletic training rules.

3. Communicate to school personnel any knowledge or information of student athletes who are violating training rules and/or are in need of assistance in their life.

4. Support the promotion of drug-free athletics within the athletic program.

5. Properly chaperon any party held in my home and be tobacco, drug and alcohol free.

Many, many thanks for your support. It is appreciated by Perry staff, community and your student athlete.

____
Parent's Name (Print)

____ ________________
Parent's Signature **Date**

____
Athlete's Name (Print)

2015-2016
PERRY LOCAL SCHOOLS
ATHLETIC CODE OF CONDUCT

The most important goal of the Perry Local Schools' Athletic Program is to provide every participant the opportunity to grow mentally, morally, physically and emotionally. To assure that the program can provide these opportunities, a degree of self-discipline is required of each participant. Self-discipline involves compliance with rules and regulations concerning personal behavior.

Rules promote order and safety and assist participants in reaching maximum performance potential. Every participant should adhere to the rules of the school and conduct himself or herself as a "good citizen" of that school and the community at all times. Dedication by each participant promotes a sense of group unity and common goals.

Compliance with the rules can help each participant learn values that carry beyond the athletic program and into daily living. In addition, research has shown that use and abuse of banned substances (tobacco, drugs and alcohol) have harmful effects on their mental, physical and emotional health.

It must also be remembered that participation in athletic activities is not a right but a privilege that will be regulated. Therefore, all students who participate in interscholastic athletics at any time must meet the following regulations from date of enrollment or date of participation, whichever comes first. Regulations concerning banned substances and inappropriate/disruptive behavior will be in effect for all athletes at all times, including summers, while enrolled as students in grades 7 through 12 in the Perry Local Schools. Conduct of an inappropriate/disruptive or criminal nature that is harmful to the individual and/or others will receive consequences appropriate to the behavior, up to and including full removal from all athletics and appropriate punishments from the school administration.

Athletes of Perry Local Schools are representatives of the school and their respective teams at all times. Therefore, any behavior that is defaming to the school, team, and/or athletes and staff, in action or through digital means (including social media), will be met with punishment fitting of the offense.

The adopted policy of the Board of Education regarding drugs, alcohol, tobacco, and criminal behavior as well as the Athletic Code of Conduct shall be distributed so that all students and their parents will be given notice that the unlawful use of drugs, alcohol, tobacco and any unlawful or unethical behavior is prohibited and subject to disciplinary action.

Each participant and parent shall sign a contract and return a copy of it to the athletic department before that athlete may begin practice.

Each participant shall abide by the terms and conditions of said contract.

Failure to comply with the regulations could jeopardize a student's athletic career.

CRIMINAL AND INAPPROPRIATE BEHAVIOR AND BANNED SUBSTANCES

Students are volunteering to participate in the interscholastic athletic program and are expected to accept the responsibilities granted them. Athletes are expected to be committed to the high degree of conduct outlined by the Athletic Code of Conduct Policy throughout their-athletic career. As a representative of Perry Local Schools, an athlete is expected to make the appropriate choices in his/her personal conduct. This code of conduct is applicable for 1 year from the date signed. Violations are cumulative for middle school athletes from grade 7 through grade 8. Violations are cumulative for high school athletes from grade 9 through grade 12. Any unfulfilled suspension at the end of the 8th grade year will carry over to high school for fulfillment purposes only.

The policy addresses possession, use, selling, offering to sell, delivering or concealing any instruments or paraphernalia for use with drug abuse (including but not limited to use of e-cigarettes and similar delivery devices).

Drugs of abuse include, but are not limited to, alcohol, tobacco (including e-cigarettes), steroids, any narcotic hallucinogens, stimulants or depressants, other harmful substances, and look-a-like drugs.

Behavior of a criminal or unethical nature could result in loss of participation and/or disciplinary action from school administrators.

If offenses occur, the following penalties will be applied:

First Violation:

1. The athlete will be suspended for 30% of the total season's sanctioned athletic contests for drug or alcohol usage and/or criminal/inappropriate behavior; for tobacco infractions, 20% of the total season's sanctioned athletic contests.
2. If said individual is not suspended from school during the 20% or 30% period, the athlete may continue to practice with the team only to prevent them from losing all their physical conditioning.
3. The athlete must attend a professional assessment or drug screening outside of school from a qualified assessment agency. The athlete will remain suspended from competition until the completion of the drug screening and/or assessment. The cost of the drug screening and assessment will be paid by the family.
4. If a violation occurs after the athlete's season ends, the suspension would take place at the beginning of the athlete's next season. For the suspension to be considered fulfilled, the entire season of the sport must be completed.
5. Seasons are determined by the OHSAA.

Second Violation:

1. Athletes will be suspended for an additional 50% of all sanctioned contests scheduled. All other requirements will remain the same as the first violation.

Third Violation:

1. The athlete will be suspended from all athletic participation for one full year from the date the third violation occurred for the use of banned substances and/or criminal/unethical behavior.

DISCIPLINARY PROCEDURE

Any violation by an athlete in grades 7-12 must be reported to the athletic director or other school administrator by the head coach of that particular sport or by the head coach at the grade level of that particular sport where the violation took place.

Any remaining percentages of penalties not served in the regular activity duration shall be recalculated by the hearing committee and applied toward the next athletic activity in which the student participates. The hearing committee is made up of the athletic director, principal, and assistant principals.

The above regulations for athletic activities are separate, above and beyond any consequences invoked by normal school disciplinary codes.

1. When a student is suspected to be in violation of any rules pertaining to the code of conduct, the principal and coach/advisor shall be notified as soon as possible.

2. A hearing committee will be established. The current extra-curricular coach/advisor of the student shall not be included on the hearing committee. At least one member of the committee will investigate the violation and report the findings to the other committee members. If the hearing committee feels action is warranted, the principal shall give a parent/guardian and the student written notice of the suspected violation and of the time and place for a hearing, which shall be scheduled within 72 hours of the notification.

3. At the hearing, the student will have an opportunity to discuss the circumstances concerning the incident and present his/her version of the incident.

4. The hearing committee shall make its recommendation for penalty assessment to the school principal. The principal or his/her designee will notify the parent and student in writing of the decision.

5. The principal's decision may be appealed to the superintendent or his/her designee. Any appeal must be sent in writing within five calendar days of the decision notification. The appeal should state the exact reason the decision is being appealed.

I have read, understand, and agree to the 2015-2016 policy stated above

______________________________ ______________________________

Athlete’s Name (Print) Organization/activity

______________________________ ______________________________

Athlete’s Signature Date

****

I have read, understand, and agree to the policy stated above and am witness to my son’s/daughter’s signature.

______________________________ ______________________________

Parent’s/Guardian’s Signature Date

****

I have presented and reviewed this policy and my rules to the above named athlete.

______________________________ ______________________________

Advisor’s/Coach’s Signature Date

If you have any questions regarding this Code of Conduct, please feel free to address them immediately with the athletic director, building administrator, and/or the head coach. Thank you.