



SOUTHLANDS CHRISTIAN

Athletics

18550 Farjardo St. Rowland Heights, CA 91748
MIDDLE SCHOOL PERMISSION SLIP

Please check the sport/s you plan to participate in for the 20__ -20__ Season

FOOTBALL VOLLEYBALL BASKETBALL SOCCER BASEBALL CHEER SOFTBALL

(PLEASE PRINT)

Student's Cell: _____

Student's E-mail _____

Student Name _____ Grade _____ Age _____ Birthdate _____ Female _____ Male _____

Address _____ City _____ Zip Code _____

Mother's Name _____ Mother's E-mail _____ Home Phone _____ Work Phone _____ Cell Phone _____

Father's Name _____ Father's E-mail _____ Home Phone _____ Work Phone _____ Cell Phone _____

(Emergency Contact if unable to reach parents)

Name _____ Home Phone _____ Work Phone _____ Cell Phone _____

I understand the student must have health insurance that meets minimal coverage as mandated by SCS to participate in sports.

Name of Insurance _____ Subscriber No. _____

Health Problems or Handicaps: _____

Drug Allergies or Other Allergic Reactions: _____

Regular Medication: _____

Activity Restrictions: _____

Physician's Name _____ Phone No. _____

Address _____ City _____ Zip Code _____

I GIVE PERMISSION for you to administer Tylenol to my child. _____ Yes _____ No

I GIVE PERMISSION for my student to travel by bus or van with an authorized driver of the school. _____ Yes _____ No

IN CASE OF A MEDICAL EMERGENCY, I HEREBY GIVE PERMISSION to the physician selected by the School Administrators present or their agents to hospitalize, secure proper treatment for, and order injection, x-ray, anesthesia or surgery for my child; as named above.

I AGREE to hold harmless the school, the employees, including but not limited to, administrators, teachers, coaches, agents and assigners for any and all injuries incurred to student during the participation in practice and competition and hereby assume all risks associated with the playing and participation of the sport including negligence.

I WILL also indemnify the school and all its employees for any injuries that the above mentioned student causes to another.

THE UNDERSIGNED HEREBY AGREES TO BEAR ALL MEDICAL COSTS INCURRED AS A RESULT OF THE FOREGOING.

Parent or Guardian Signature / Date

Parent initials

I understand that the **PHYSICAL EXAM FORM AND SPORT FEE** must be turned in prior to the start of practice. You may use the following forms of payment - **CASH / CHECK / MASTERCARD / VISA**

Parent initials

I understand my student may be released from classes early on scheduled game days. They will be responsible to make up any class work missed.

Parent initials

I understand if my student becomes ill and does not attend school on the day of a game he will not be able to play. He must be in attendance for half of the day.

*This form will be kept on file in the sports department for the school year, please notify us of any changes.
Student, please fill out the Code of Ethics from CIF*



Code of Ethics - Athletes

Athletics is an integral part of the school’s total educational program. All school activities, curricular and extra-curricular, in the classroom and on the playing field, must be congruent with the school’s stated goals and objectives established for the intellectual, physical, social and moral development of its students. It is within this context that the following Code of Ethics is presented.

As an athlete, I understand that it is my responsibility to:

1. Place academic achievement as the highest priority.
2. Show respect for teammates, opponents, officials and coaches.
3. Respect the integrity and judgment of game officials.
4. Exhibit fair play, sportsmanship and proper conduct on and off the playing field.
5. Maintain a high level of safety awareness.
6. Refrain from the use of profanity, vulgarity and other offensive language and gestures.
7. Adhere to the established rules and standards of the game to be played.
8. Respect all equipment and use it safely and appropriately.
9. Refrain from the use of alcohol, tobacco, illegal and non-prescriptive drugs, anabolic steroids or any substance to increase physical development or performance that is not approved by the United States Food and Drug Administration, Surgeon General of the United States or American Medical Association.
10. Know and follow all state, section and school athletic rules and regulations as they pertain to eligibility and sports participation.
11. Win with character, lose with dignity.
12. Respect and represent the Christian values of Southlands Christian School.

As a condition of membership in the CIF, all schools shall adopt policies prohibiting the use and abuse of androgenic/anabolic steroids. All member schools shall have participating students and their parents, legal guardian/caregiver agree that the athlete will not use steroids without the written prescription of a fully licensed physician (as recognized by the AMA) to treat a medical condition (Article 523).

By signing below, both the participating student athlete 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 recognize that under CIF Bylaw 202, there could be penalties for false or fraudulent information.

We also understand that the _____ (school/school district name) policy regarding the use of illegal drugs will be enforced for any violations of these rules.

Printed Name of Student Athlete

Signature of Student Athlete Date

Signature of Parent/Caregiver Date

A copy of this form must be kept on file in the athletic director’s office at the local high school on an annual basis and the Principal’s Statement of Compliance must be on file at the CIF Southern Section office.

Preparticipation Physical Evaluation

HISTORY FORM

Date of Exam _____

Name _____ Sex _____ Age _____ Date of birth _____

Grade _____ School _____ Sport(s) _____

Address _____ Phone _____

Personal Physician _____

In case of emergency, contact:

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

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

- | | Yes | No | | | | | |
|---|--------------------------|--------------------------|-----------|-------|------------|---------------|------------|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 2. Do you have an ongoing medical condition (like diabetes or asthma)? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 4. Do you have allergies to medicines, pollens, foods, or stinging insects? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 5. Have you ever passed out or nearly passed out DURING exercise? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 6. Have you ever passed out or nearly passed out AFTER exercise? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 7. Have you ever had discomfort, pain, or pressure in your chest during exercise? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 8. Does your heart race or skip beats during exercise? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 9. Has a doctor ever told you that you have (check all that apply):
<input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur
<input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection | | | | | | | |
| 10. Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram) | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 11. Has anyone in your family died for no apparent reason? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 12. Does anyone in your family have a heart problem? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 13. Has any family member or relative died of heart problems or of sudden death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 14. Does anyone in your family have Marfan syndrome? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 15. Have you ever spent the night in a hospital? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 16. Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below: | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below: | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 19. Have you had a bone or joint injury that required x-rays MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below: | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| Head | Neck | Shoulder | Upper Arm | Elbow | Forearm | Hand/ Fingers | Chest |
| Upper Back | Lower Back | Hip | Thigh | Knee | Calf/ Shin | Ankle | Foot/ Toes |
| 20. Have you ever had a stress fracture? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 22. Do you regularly use a brace or assistive device? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 23. Has a doctor ever told you that you have asthma or allergies? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |

- | | Yes | No |
|--|--------------------------|--------------------------|
| 24. Do you cough, wheeze, or have difficulty breathing during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Is there anyone in your family who has asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Have you ever used an inhaler or taken asthma medicine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Have you had infectious mononucleosis (mono) within the last month? | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Do you have any rashes, pressure sores, or other skin problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Have you had a herpes skin infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Have you been hit in the head and been confused or lost your memory? | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Do you have headaches with exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Have you ever been unable to move your arms or legs after being hit or falling? | <input type="checkbox"/> | <input type="checkbox"/> |
| 37. When exercising in the heat, do you have severe muscle cramps or become ill? | <input type="checkbox"/> | <input type="checkbox"/> |
| 38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. Do you wear glasses or contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 41. Do you wear protective eyewear, such as goggles or a face shield? | <input type="checkbox"/> | <input type="checkbox"/> |
| 42. Are you happy with your weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 43. Are you trying to gain or lose weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 44. Has anyone recommended you change your weight or eating habits? | <input type="checkbox"/> | <input type="checkbox"/> |
| 45. Do you limit or carefully control what you eat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 46. Do you have any concerns that you would like to discuss with a doctor? | <input type="checkbox"/> | <input type="checkbox"/> |
| FEMALES ONLY | | |
| 47. Have you ever had a menstrual period? | <input type="checkbox"/> | <input type="checkbox"/> |
| 48. How old were you when you had your first menstrual period? _____ | | |
| 49. 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.

Signature of Athlete _____ Signature of Parent/Guardian _____ Date _____

Preparticipation Physical Evaluation

PHYSICAL EXAMINATION FORM

Name _____ Date of Birth _____

Height _____ Weight _____ % Body Fat (optional) _____ Pulse _____ BP ____ / ____ (____ / ____, ____ / ____)

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

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)+			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

*Multiple-examiner set-up only.

+Having a third party present is recommended for the genitourinary examination.

Notes: _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

Preparticipation Physical Evaluation

CLEARANCE FORM

Name _____ Sex _____ Age _____ Date of birth _____

- Cleared without restriction
- Cleared, with recommendations for further evaluation or treatment for: _____

Not Cleared for All sports Certain sports: _____ Reason: _____

Recommendations: _____

EMERGENCY INFORMATION

Allergies _____

Other Information _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

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Preparticipation Physical Evaluation

CLEARANCE FORM

Name _____ Sex _____ Age _____ Date of birth _____

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- Cleared, with recommendations for further evaluation or treatment for: _____

Not Cleared for All sports Certain sports: _____ Reason: _____

Recommendations: _____

EMERGENCY INFORMATION

Allergies _____

Other Information _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

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