



CALVARY CHAPEL HIGH SCHOOL

3800 S. Fairview Road, Santa Ana, CA 92704

Phone 714-662-7485 Fax 714-979-3515

Athletic Participation

California Interscholastic Federation (CIF) requires ALL high school athletes who participate in a sport to complete a physical **BEFORE** The first day of practice.

The best time to schedule your son/daughter's physical would be in June, when your physician is not as busy with back to school physicals. The athlete's physical is valid for one year from the date of the physical. **No** athlete will be allowed to participate without a physical.

Take the attached physical packet filled out to your doctor and he/she will complete his/her portion and sign it. Then return the physical form as soon as possible to Mike Rausch in the High School Office and **no** one else.

If you have any questions please call Mike Rausch, Athletic Director, at 714-662-7485, x 2-2-1 during office hours, or ext. 2452 after hours.

CCHS ATHLETIC CODE
AGREEMENT FOR ATHLETIC PARTICIPATION

Conduct and Behavior

Athletics at the high school level are subject to great public exposure. Our behavior will be a testimony to our Lord. Be mindful of this at all times. ***Infractions on or off campus of School Rules will result in the athlete being suspended or dismissed from the team.*** In addition, each Coach will have specific team rules that must be followed.

The School Rules include, but are not limited to:

1. Drug or alcohol involvement
2. Fighting
3. Extreme insubordination
4. Smoking or any kind of tobacco use
5. Stealing
6. Truancy

Quitting a Sport

It is our belief that you should “count the cost” before making a **COMMITMENT** to a team. Once made, that commitment should be completed. Therefore, the following guidelines have been set:

The first three weeks of practice are considered a ***trial period***. Anyone who chooses not to continue during this period will not be penalized. However, after the trial period, ***an athlete who quits or is removed by parental choice*** will have the following consequences:

- The athlete may not begin another sport until the current season ends;
- The athlete will receive a failing grade for the period of time the sport began until the date they quit;
- Any fees paid will be forfeited; and
- If the athlete’s spirit pack costs were waived (scholarship), they must reimburse the sport for those costs.

Any hardship cases must be brought to the Athletic Director and they will be prayerfully considered.

If an athlete or their parents have any questions about the Agreement for Athletic Participation and Athletic Consent / Insurance (“Agreements”), they can discuss them with their Coach or the Athletic Director. However, the Agreements must be signed by the athlete and a parent, and submitted along with the athlete’s physical examination before the first day of practice. The signatures on these forms indicate that the athlete and parent have read, and understand the provisions on both documents.

Athlete’s Name

Signature

Date

Parent’s Name

Signature

Date

CALVARY CHAPEL HIGH SCHOOL ATHLETIC CONSENT / INSURANCE

Participant's Name (Please print- Last, First, Middle Initial)

Residence Address (Number, Street, City, Zip Code)

Phone (Home Number) (Work Number)

PARENT'S CONSENT: I hereby give my consent for: _____
(Last Name) (First Name)

to compete in sports. I give my consent for him/her to go with school authorized drivers on athletic trips. I understand that my son/daughter must comply with the eligibility requirements.

I have read, understand and agree to the provision of the CCHS athletic code.

Date

Signature of Parent or Legal Guardian

The school makes every effort to protect all students, however it does not assume liability for injury. State Law requires that a student of any educational institution, who practices or participates in any athletic event, must have medical insurance for accidental injuries. CCHS provides this coverage for all sports, however is **secondary** to any coverage that is already being provided.

This is to certify that my son/daughter _____
(Last Name) (First Name)

is protected under the terms of an insurance policy which provides primary medical coverage for accidental injury. This coverage will be in effect from this signature date and maintained by me until the last day of school attendance.

Insurance Company Policy Number Phone Number

Parent or Legal Guardian Signature

Date

CONSENT TO TREAT MINOR

I (We) being the parent or legal guardian of _____, a minor the age of _____ do hereby consent, authorize and request Dr. _____ to administer such treatment deemed advisable, necessary or requested on the above minor. I (We) agree to hold him/her free and harmless from any claims, suits for damages or complications that may result from such treatment.

Signed: _____ Date: _____

Parent or Legal Guardian

Witness: _____

Preparticipation Physical Examination Form

(Please type or print)

Student's Name _____ Birth Date _____ Sex _____ Grade _____

Last First Middle

City _____ School _____ Place of Birth _____

Student's Address _____

Street City Zip Telephone

Parent(s) or Guardian(s) Name _____

Address (if different than student) _____

Street City Zip Telephone

Family Physician's Name, Address, Telephone _____

History

This section is to be carefully completed by the student and his/her parent(s) or legal guardian(s) before participation in interscholastic athletics in order to help detect possible risks.

Explain "YES" answers below. Circle questions you don't know the answer to.

	Yes	No		Yes	No
1. Have you had a medical illness or injury since your last checkup or sports physical? Do you have an ongoing or chronic illness?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized overnight? Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler? Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
4. Do you think you are in good health?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any allergies (for example, to pollen, medicine, food, or stinging insect)?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had a rash or hives develop during or after exercise? Have you ever passed out during or after exercise? Have you ever been dizzy during or after exercise? Have you ever had chest pain during or after exercise? Do you get tired more quickly than your friends do during exercise? Have you ever had racing of your heart or skipped heartbeats? Have you had high blood pressure or high cholesterol? Have you ever been told you have a heart murmur? Has any family member or relative died of heart problems or of sudden death before age 50? Is there a family history of heart problems in a close relative younger than age 50 (examples are enlarged heart, cardiomyopathy, long QT interval, abnormal EKG, abnormal heart rhythm)? Have you had a severe heart infection (for example, myocarditis or pericarditis)? Is there a family history of Marfan's Syndrome? Has a physician ever denied or restricted your participation in sports for any heart problem?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had a severe viral infection within the last month (for example, mononucleosis)?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever had a head injury or concussion? Have you ever been knocked out, become unconscious or lost your memory? Have you ever had a seizure? Do you have frequent or severe headaches? Have you ever had numbness or tingling in your arms, hands, legs or feet? Have you ever had a stinger, burner or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
			10. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>
			11. Do you cough, wheeze or have trouble breathing during or after activity? Do you have asthma? Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
			12. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>
			13. Have you had any problems with your eyes or vision? Do you wear glasses, contacts or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>
			14. Have you ever had a sprain, strain or swelling after injury? Have you broken or fractured any bones or dislocated any joints? Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? <i>If yes, check the appropriate box and explain below.</i> <input type="checkbox"/> Head <input type="checkbox"/> Upper Arm <input type="checkbox"/> Hand <input type="checkbox"/> Knee <input type="checkbox"/> Neck <input type="checkbox"/> Elbow <input type="checkbox"/> Finger <input type="checkbox"/> Shin/calf <input type="checkbox"/> Back <input type="checkbox"/> Forearm <input type="checkbox"/> Hip <input type="checkbox"/> Ankle <input type="checkbox"/> Chest <input type="checkbox"/> Wrist <input type="checkbox"/> Thigh <input type="checkbox"/> Foot <input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>
			15. Do you want to weigh more or less than you do now? Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
			16. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
			17. Record the dates of your most recent immunizations (shots) for: Tetanus _____ Measles _____ Hepatitis B _____ Chickenpox _____		
			18. FEMALES ONLY When was your first menstrual period? _____ When was your most recent menstrual period? _____ How much time do you usually have from the start of one period to the start of another? _____ How many periods have you had in the last year? _____ What was the longest time between periods in the last year? _____		
			19. ALL PARTICIPANTS Explain "Yes" answers here: _____ _____ _____ _____ _____ _____		

NOTE: CONSENT AND HIPAA RELEASE FORMS THAT MUST BE SIGNED BY BOTH THE PARENT AND THE STUDENT ARE ON A SEPARATE SHEET.

NOTE: History and All Consent Forms Must be Completed Prior to Physical Examination

Modified from the form approved by the American Academy of Family Physicians, the American Academy of Pediatrics, the American Medical Society for Sports Medicine, the American Orthopedic Society for Sports Medicine and the American Osteopathic Academy of Sports Medicine.

Physical Examination

(Please type or print)

Student's Name _____ Birth Date _____
Last First Middle

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

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

	Normal	Abnormal Findings	Initials*
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MEDICAL

Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			

MUSCULOSKELETAL

Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*Station-based examination only

Clearance

- Cleared
- Cleared after completing evaluation/rehabilitation for: _____

- Not cleared for: _____ Reason: _____
- Recommendations: _____

I certify that I have on this date examined this student and that, on the basis of the examination requested by the school authorities and the student's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities (Note exceptions above).

Physician's Name and Address (stamp or print)
 If the Physician's Assistant (P.A.) or Advanced Nurse Practitioner (A.N.P.) performed the exam, name and address of collaborating physician or physician group:

Examiner's Signature **Date**

Examiner's Telephone Number

NOTE: History and Consent Must be Completed Prior to Physical Examination