Calvary Chapel High School
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 packet filled out to your physical and your doctor will complete his portion and sign it. Then return the physical as soon as possible to Mike Rausch or Kim Jones in the high school office and **no** one else.

If you have any questions please call Mike Rausch, Athletic Director, at 714-662-7485, 2-2-1 during office hours, 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 of school rules on or off campus may 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

Dropping A Sport

It is our belief that you should "count the cost" before making a commitment to a team. We also believe that you should always finish what you start. Once made, a commitment should be completed. Therefore, the following guidelines have been established:
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 my not begin another sport until the current season ends.
- The athlete will receive a failing grade.
- All fees will be forfeited

If an athlete or their parents have any questions about the Agreement for Athletic Participation and Athletic Consent/Insurance, they can discuss them with their coach or the Athletic Director. These forms must be signed by the athlete and parent and submitted 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 agree to the provisions on these documents.

_____ _____ _____
Print Athlete's Name Athlete's Signature Date

_____ _____ _____
Print Parent's Name Parent's 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 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

_____

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 herby 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.

_____ _____ _____

Print Parent's Name Parent's Signature Date

Revised 7/1/05
Mandatory

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?	☐	☐
2. Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	☐
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5. Have you ever passed out or nearly passed out DURING exercise?	☐	☐
6. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
8. Does your heart race or skip beats during exercise?	☐	☐
9. Has a doctor ever told you that you have (check all that apply): ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection		
10. Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)	☐	☐
11. Has anyone in your family died for no apparent reason?	☐	☐
12. Does anyone in your family have a heart problem?	☐	☐
13. Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
14. Does anyone in your family have Marfan syndrome?	☐	☐
15. Have you ever spent the night in a hospital?	☐	☐
16. Have you ever had surgery?	☐	☐
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:	☐	☐
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	☐	☐
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:	☐	☐

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?	☐	☐
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
22. Do you regularly use a brace or assistive device?	☐	☐
23. Has a doctor ever told you that you have asthma or allergies?	☐	☐
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
25. Is there anyone in your family who has asthma?	☐	☐
26. Have you ever used an inhaler or taken asthma medicine?	☐	☐
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
28. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
29. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
30. Have you had a herpes skin infection?	☐	☐
31. Have you ever had a head injury or concussion?	☐	☐
32. Have you been hit in the head and been confused or lost your memory?	☐	☐
33. Have you ever had a seizure?	☐	☐
34. Do you have headaches with exercise?	☐	☐
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
36. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
37. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
39. Have you had any problems with your eyes or vision?	☐	☐
40. Do you wear glasses or contact lenses?	☐	☐
41. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
42. Are you happy with your weight?	☐	☐
43. Are you trying to gain or lose weight?	☐	☐
44. Has anyone recommended you change your weight or eating habits?	☐	☐
45. Do you limit or carefully control what you eat?	☐	☐
46. Do you have any concerns that you would like to discuss with a doctor?	☐	☐
FEMALES ONLY		
47. Have you ever had a menstrual period?	☐	☐

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