

GEORGETOWN INDEPENDENT SCHOOL DISTRICT
ATHLETIC DEPARTMENT

May 1, 2011

Dear Parents of Georgetown ISD Athletes:

In order to prepare our student athletes for the upcoming athletic seasons, there are several required forms and procedures that need your attention. The following items will update you on the requirements for your child's participation:

1. **All athletes entering the 7th grade through the 12th grade must have a physical examination.** GISD requires every athlete to have an annual physical. **The physical form that is distributed by our athletic training staff is the only physical form accepted due to UIL regulations.**
2. **IMPORTANT: Physicals must be dated after May 1, 2011 to be accepted for the 2011-2012 school year.**
3. All paperwork for the 7^h & 8th grade athletes may be turned in to their middle school athletic coordinators before May 27, 2011. After May 27, 2011, the paperwork should be turned in to the middle school athletic coordinators beginning the first day of school.
4. All athletes may turn their paperwork in to the Athletic Training Room until May 27, 2011. After May 27, 2011, no paperwork may be turned in to the Athletic Training Room until July 25, 2011.
5. **DO NOT MAIL IN THE PHYSICAL PACKETS OR SEND THEM THROUGH INTERCAMPUS MAIL.**
6. **ONLY COMPLETED PACKETS WILL BE ACCEPTED. Two emergency forms must be filled out completely.**
7. **No athlete will be allowed to begin participating in athletics and/or after school workouts until all paperwork is on file with the Athletic Training Department.**
8. **The catastrophic insurance must be paid when turning in the physical packet. The fee is \$5.00 for all sports except football. Football players must pay \$10.00.**
9. The Athletic Training room will be open until May 27, 2011. It will be closed during the summer and will re-open beginning July 25, 2011. Hours will vary due to schedules. **Please call before coming by the Athletic Training Room.**

Catastrophic Health Insurance:

All students participating in athletics (including try-outs) in the Georgetown ISD must purchase a catastrophic insurance policy arranged by the school district. Generally, this blanket policy pays for medical expenses which exceed \$25,000 per occurrence (see plan document for details). The cost for this insurance is \$10.00 for a student who participates in football and \$5.00 for a student who participates in any sport other than football.

Primary Health Insurance:

It is highly recommended that all students who are participating in athletics have personal health insurance. **IF A STUDENT DOES NOT HAVE VALID PERSONAL INSURANCE COVERAGE, THE GISD VOLUNTARY POLICY IS HIGHLY RECOMMENDED.** For additional information about the GISD voluntary policy please contact the Athletic Training Department. The Catastrophic Insurance is different from the GISD Voluntary Insurance Policy.

If you have any questions, please do not hesitate to contact Ms. Morales at 943-5000, ext 7213 or Mr. Hennessey at 943-5000, ext. 7200 or visit our website at www.georgetownisd.org/ghs/trainers .

Sincerely,

Phil Blue
Athletic Director

GISD Physical Packet Check List 2011-2012

ONLY COMPLETED PACKETS WILL BE ACCEPTED

Please Complete All Forms In Pen

_____ Athlete Information Sheet

- Parent/ Guardian's initials by "Releases and Waivers" section
- Parent/ Guardian's signature at the bottom of the page

_____ UIL Medical History Form (Revised 1/6/09)

- Signed by Parent/Guardian and Student-Athlete

_____ UIL Physical Form

- Physician's signature and date of physical
- Must be dated AFTER May 1, 2011

_____ UIL Acknowledgement of Rules Form (Revised Jan. 2011)

- Signed by Parent/Guardian and Student-Athlete

_____ UIL Steroid Testing Form

- Signed by Parent/Guardian and Student – Athlete
- To be completed by all Student – Athletes (Grades 7-12)

_____ Consent for Cognitive Testing (ImPACT Concussion Test)

- Complete Primary Care Physician section
- Signed by Parent/Guardian

_____ Student – Athlete Emergency Forms (Please Complete Two Forms)

- Signed by Parent/Guardian (Two signatures on each form)

_____ Money for catastrophic insurance

(\$5.00 for all sports except football, football athletes \$10.00)
(Check may be made payable to GISD Athletics)

**Por información en español, por favor llame a Vanessa Morales, en
(512) 943-5000, ext 7213**

GEORGETOWN ISD - ATHLETE INFORMATION**2011-2012 SCHOOL YEAR**

Name: _____ Birthdate: _____ Gender: Male Female

(Circle One)

Sport(s): _____ Today's Date: _____ Student ID #: _____

Grade (2011-2012): _____ School (Please Circle One): GHS EVHS Benold Tippit Forbes

Current Address: _____
Street/P.O. Box City State Zip Code

Please indicate medical alerts such as allergies, contact lenses, asthma, etc.: _____

MALE PARENT/GUARDIAN'S INFORMATION

Male Parent/Guardian's Name: _____ Relationship to Student: _____

Daytime/Work Phone: _____ Cell Phone: _____ E-Mail: _____

FEMALE PARENT/GUARDIAN'S INFORMATION

Female Parent/Guardian's Name: _____ Relationship to Student: _____

Daytime/Work Phone: _____ Cell Phone: _____ E-Mail: _____

EMERGENCY CONTACT INFORMATION (Other than Parent/Guardian)

Emergency Contact's Name/Relationship to Student: _____ Phone: _____

-----IMPORTANT INSURANCE NOTICES-----**Catastrophic Health Insurance:**

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-----RELEASES AND WAIVERS-----

Signify your approval by signing your initials in the space before the statement(s) and signing below:

1. In the event of an injury or illness to the above-named student, I hereby authorize a representative of GISD to secure emergency medical treatment for the above-named student from any healthcare provider.

2. I understand that, in addition to any personal health insurance coverage on my child, I must purchase catastrophic medical insurance arranged by GISD. In addition, I understand that I will be financially responsible, either with personal health insurance or other means, for medical treatment needed by my child. I authorize GISD Athletic Trainer(s) to file an electronic claim form for the catastrophic insurance if the situation arises.

3. I hereby authorize the release of medical records and information to the GISD Athletic Trainer(s) and healthcare providers as needed for treatment of injuries and illnesses to my child.

4. I authorize GISD Athletic Trainer(s) to administer non-prescription medication to my child.

5. I certify that the information provided on this form is true and correct to the best of my knowledge.

Parent/Guardian Signature: _____**Date:** _____

PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

REVISED 1-6-09

This **MEDICAL HISTORY FORM** must be completed **annually** by parent (or guardian) and student in order for the student to participate in athletic activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an athletic event.

Student's Name: (print) _____ Sex _____ Age _____ Date of Birth _____
 Address _____ Phone _____
 Grade _____ School _____
 Personal Physician _____ Phone _____

In case of emergency, contact:

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

Explain "Yes" answers in the box below. Circle questions you don't know the answers to. Any Yes answer to questions 1, 2, 3, 4, 5, or 6 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physician assistant, chiropractor, or nurse practitioner is required before any participation in UIL practices, games or matches**

| | Yes | No | | Yes | No |
|--|--------------------------|--------------------------|--|----------------------------------|------------------------------------|
| 1. Have you had a medical illness or injury since your last check up or sports physical? | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you ever gotten unexpectedly short of breath with exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you been hospitalized overnight in the past year? | <input type="checkbox"/> | <input type="checkbox"/> | Do you have asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | Do you have seasonal allergies that require medical treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 14. 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"/> |
| Have you ever had chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 15. Have you ever had a sprain, strain, or swelling after injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you get tired more quickly than your friends do during exercise? | <input type="checkbox"/> | <input type="checkbox"/> | Have you broken or fractured any bones or dislocated any joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had racing of your heart or skipped heartbeats? | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had high blood pressure or high cholesterol? | <input type="checkbox"/> | <input type="checkbox"/> | If yes, check appropriate box and explain below. | | |
| Have you ever been told you have a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Head | <input type="checkbox"/> Elbow | <input type="checkbox"/> Hip |
| Has any family member or relative died of heart problems or of sudden unexpected death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Neck | <input type="checkbox"/> Forearm | <input type="checkbox"/> Thigh |
| Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome or other ion channelopathy (Brugada syndrome, etc), Marfan's syndrome, or abnormal heart rhythm? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Back | <input type="checkbox"/> Wrist | <input type="checkbox"/> Knee |
| Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Chest | <input type="checkbox"/> Hand | <input type="checkbox"/> Shin/Calf |
| Has a physician ever denied or restricted your participation in sports for any heart problems? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Finger | <input type="checkbox"/> Ankle |
| 4. Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Upper Arm | <input type="checkbox"/> | <input type="checkbox"/> Foot |
| Have you ever been knocked out, become unconscious, or lost your memory? | <input type="checkbox"/> | <input type="checkbox"/> | 16. Do you want to weigh more or less than you do now? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, how many _____ When was the last _____ times? _____ concussion? | | | Do you lose weight regularly to meet weight requirements for your sport? | <input type="checkbox"/> | <input type="checkbox"/> |
| How severe was each one? (Explain below) | | | 17. Do you feel stressed out? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> | 18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have frequent or severe headaches? | <input type="checkbox"/> | <input type="checkbox"/> | Females Only | | |
| Have you ever had numbness or tingling in your arms, hands, legs, or feet? | <input type="checkbox"/> | <input type="checkbox"/> | 19. When was your first menstrual period? _____ | | |
| Have you ever had a stinger, burner, or pinched nerve? | <input type="checkbox"/> | <input type="checkbox"/> | When was your most recent menstrual period? _____ | | |
| 5. Are you missing any paired organs? | <input type="checkbox"/> | <input type="checkbox"/> | How much time do you usually have from the start of one period to the start of another? _____ | | |
| 6. Are you under a doctor's care? | <input type="checkbox"/> | <input type="checkbox"/> | How many periods have you had in the last year? _____ | | |
| 7. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler? | <input type="checkbox"/> | <input type="checkbox"/> | What was the longest time between periods in the last year? _____ | | |
| 8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? | <input type="checkbox"/> | <input type="checkbox"/> | An individual answering in the affirmative to any question relating to a possible cardiovascular health issue (question three above), as identified on the form, should be restricted from further participation until the individual is examined and cleared by a physician, physician assistant, chiropractor, or nurse practitioner. | | |
| 9. Have you ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | **EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary): | | |
| 10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| 11. Have you ever become ill from exercising in the heat? | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| 12. Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |

It is understood that even though protective equipment is worn by the athlete, whenever needed, the possibility of an accident still remains. Neither the University Interscholastic League nor the school assumes any responsibility in case an accident occurs.

If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student.

If, between this date and the beginning of athletic competition, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide truthful responses could subject the student in question to penalties determined by the UIL

Student Signature: _____ Parent/Guardian Signature: _____ Date: _____

THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE OR CONTEST BEFORE, DURING OR AFTER SCHOOL.

For School Use Only:

This Medical History Form was reviewed by: Printed Name _____ Date _____ Signature _____

PREPARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAMINATION

Student's Name _____ Sex _____ Age _____ Date of Birth _____

Height _____ Weight _____ % Body fat (optional) _____ Pulse _____ BP _____/_____/_____ (_____/_____, ____/_____)
brachial blood pressure while sitting

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

As a minimum requirement, this **Physical Examination Form** must be completed prior to junior high athletic participation and again prior to first and third years of high school athletic participation. It **must** be completed if there are yes answers to specific questions on the student's MEDICAL HISTORY FORM on the reverse side. *** Local district policy may require an annual physical exam.**

NORMAL

ABNORMAL FINDINGS

INITIALS*

| | NORMAL | ABNORMAL FINDINGS | INITIALS* |
|--|--------|-------------------|-----------|
| MEDICAL | | | |
| Appearance | | | |
| Eyes/Ears/Nose/Throat | | | |
| Lymph Nodes | | | |
| Heart-Auscultation of the heart in the supine position. | | | |
| Heart-Auscultation of the heart in the standing position. | | | |
| Heart-Lower extremity pulses | | | |
| Pulses | | | |
| Lungs | | | |
| Abdomen | | | |
| Genitalia (males only) | | | |
| Skin | | | |
| Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis) | | | |

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: _____

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner, will not be accepted.

Name (print/type) _____ Date of Examination: _____

Address: _____

Phone Number: _____

Signature: _____

Must be completed before a student participates in any practice, before, during or after school, (both in-season and out-of-season) or games/matches.

ACKNOWLEDGEMENT OF RULES

Attention School Authorities: This form must be signed yearly by both the student and parent/guardian and be on file at your school before the student may participate in any practice session, scrimmage, or contest. A copy of the student's medical history and physical examination form signed by a physician or medical history form signed by a parent must also be on file at your school.

Student's Name _____ Date of Birth _____

Current School _____

Parent or Guardian's Permit

I hereby give my consent for the above student to compete in University Interscholastic League approved sports, and travel with the coach or other representative of the school on any trips.

It is understood that even though protective equipment is worn by the athlete whenever needed, the possibility of an accident still remains. Neither the University Interscholastic League nor the high school assumes any responsibility in case an accident occurs.

I have read and understand the University Interscholastic League rules on the reverse side of this form and agree that my son/daughter will abide by all of the University Interscholastic League rules.

The undersigned agrees to be responsible for the safe return of all athletic equipment issued by the school to the above named student.

If, in the judgement of any representatives of the school, the above student needs immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given to said student by any physician, licensed athletic trainer, nurse, hospital, or school representative; and I do hereby agree to indemnify and save harmless the school and any school representative from any claim by any person whomsoever on account of such care and treatment of said student.

I have been provided the UIL Parent Information Manual regarding health and safety issues including concussions and my responsibilities as a parent/guardian. I understand that failure to provide accurate and truthful information on UIL forms could subject the student in question to penalties determined by the UIL.

The UIL Parent Information Manual is located at www.uil texas.org/files/athletics/manuals/parent-information-manual.pdf.

Your signature below gives authorization that is necessary for the school district, its licensed athletic trainers, coaches, associated physicians and student insurance personnel to share information concerning medical diagnosis and treatment for your student.

To the Parent: Check any activity in which this student is allowed to participate.

| | | | |
|---------------|----------|-------------------|---------------|
| Baseball | Football | Softball | Tennis |
| Basketball | Golf | Swimming & Diving | Track & Field |
| Cross Country | Soccer | Team Tennis | Volleyball |
| Wrestling | | | |

Date _____

Signature of parent or guardian _____

Street address _____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____

GENERAL INFORMATION

School coaches may not:

- Transport, register, or instruct students in grades 7-12 from their attendance zone in non-school baseball, basketball, football, soccer, softball, or volleyball camps (exception: See Section 1209 of the Constitution and Contest Rules).
- Give any instruction or schedule any practice for an individual or a team during the off-season except during the one in school day athletic period in baseball, basketball, football, soccer, softball, or volleyball
- Schools and school booster clubs may not provide funds, fees, or transportation for non-school activities.

GENERAL ELIGIBILITY RULES

According to UIL standards, students could be eligible to represent their school in interscholastic activities if they:

- are not 19 years of age or older on or before September 1 of the current scholastic year. (See Section 446 of the Constitution and Contest Rules for exception).
- have not graduated from high school.
- are enrolled by the sixth class day of the current school year or have been in attendance for fifteen calendar days immediately preceding a varsity contest.
- are full-time students in the participant high school they wish to represent.
- initially enrolled in the ninth grade not more than four years ago.
- are meeting academic standards required by state law.
- live with their parents inside the school district attendance zone their first year of attendance. (Parent residence applies to varsity athletic eligibility only.) When the parents do not reside inside the district attendance zone the student could be eligible if: the student has been in continuous attendance for at least one calendar year and has not enrolled at another school; no inducement is given to the student to attend the school (for example: students or their parents must pay their room and board when they do not live with a relative; students driving back into the district should pay their own transportation costs); and it is not a violation of local school or TEA policies for the student to continue attending the school. Students placed by the Texas Youth Commission are covered under Custodial Residence (see Section 442 of the Constitution and Contest Rules).
- have observed all provisions of the Awards Rule.
- have not been recruited. (Does not apply to college recruiting as permitted by rule.)
- have not violated any provision of the summer camp rule. Incoming 10-12 grade students shall not attend a baseball, basketball, football, soccer, or volleyball camp in which a seventh through twelfth grade coach from their school district attendance zone, works with, instructs, transports or registers that student in the camp. Students who will be in grades 7, 8, and 9 may attend one baseball, one basketball, one football, one soccer, one softball, and one volleyball camp in which a coach from their school district attendance zone is employed, for no more than six consecutive days each summer in each type of sports camp. Baseball, Basketball, Football, Soccer, Softball, and Volleyball camps where school personnel work with their own students may be held in May, after the last day of school, June, July and August prior to the second Monday in August. If such camps are sponsored by school district personnel, they must be held within the boundaries of the school district and the superintendent or his designee shall approve the schedule of fees.
- have observed all provisions of the Athletic Amateur Rule. Students may not accept money or other valuable consideration (tangible or intangible property or service including anything that is usable, wearable, salable or consumable) for participating in any athletic sport during any part of the year. Athletes shall not receive valuable consideration for allowing their names to be used for the promotion of any product, plan or service. Students who inadvertently violate the amateur rule by accepting valuable consideration may regain athletic eligibility by returning the valuable consideration. If individuals return the valuable consideration within 30 days after they are informed of the rule violation, they regain their athletic eligibility when they return it. If they fail to return it within 30 days, they remain ineligible for one year from when they accepted it. During the period of time from when students receive valuable consideration until they return it, they are ineligible for varsity athletic competition in the sport in which the violation occurred. Minimum penalty for participating in a contest while ineligible is forfeiture of the contest.
- did not change schools for athletic purposes.

I understand that failure to provide accurate and truthful information on UIL forms could subject the student in question to penalties determined by the UIL.

I have read the regulations cited above and agree to follow the rules.

Date

Signature of student



University Interscholastic League



Parent and Student Agreement/Acknowledgement Form Anabolic Steroid Use and Random Steroid Testing

- Texas state law prohibits possessing, dispensing, delivering or administering a steroid in a manner not allowed by state law.
- Texas state law also provides that body building, muscle enhancement or the increase in muscle bulk or strength through the use of a steroid by a person who is in good health is not a valid medical purpose.
- Texas state law requires that only a licensed practitioner with prescriptive authority may prescribe a steroid for a person.
- Any violation of state law concerning steroids is a criminal offense punishable by confinement in jail or imprisonment in the Texas Department of Criminal Justice.

STUDENT ACKNOWLEDGEMENT AND AGREEMENT

As a prerequisite to participation in UIL athletic activities, I agree that I will not use anabolic steroids as defined in the UIL Anabolic Steroid Testing Program Protocol. I have read this form and understand that I may be asked to submit to testing for the presence of anabolic steroids in my body, and I do hereby agree to submit to such testing and analysis by a certified laboratory. I further understand and agree that the results of the steroid testing may be provided to certain individuals in my high school as specified in the UIL Anabolic Steroid Testing Program Protocol which is available on the UIL website at www.uil.utexas.edu. I understand and agree that the results of steroid testing will be held confidential to the extent required by law. I understand that failure to provide accurate and truthful information could subject me to penalties as determined by UIL.

Student Name (Print): _____ Grade (9-12) _____

Student Signature: _____ Date: _____

PARENT/GUARDIAN CERTIFICATION AND ACKNOWLEDGEMENT

As a prerequisite to participation by my student in UIL athletic activities, I certify and acknowledge that I have read this form and understand that my student must refrain from anabolic steroid use and may be asked to submit to testing for the presence of anabolic steroids in his/her body. I do hereby agree to submit my child to such testing and analysis by a certified laboratory. I further understand and agree that the results of the steroid testing may be provided to certain individuals in my student's high school as specified in the UIL Anabolic Steroid Testing Program Protocol which is available on the UIL website at www.uil.utexas.edu. I understand and agree that the results of steroid testing will be held confidential to the extent required by law. I understand that failure to provide accurate and truthful information could subject my student to penalties as determined by UIL.

Name (Print): _____

Signature: _____ Date: _____

Relationship to student: _____



**Georgetown ISD
Athletic Training**

CONSENT FOR COGNITIVE TESTING and RELEASE OF INFORMATION

I give my permission for (name of child) _____

(child's date of birth) _____

to have a baseline and post-concussion *ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) administered by Georgetown ISD. I understand that my child may need to be tested more than once, depending upon the results of the test, as compared to my child's baseline test, which will be on file with GISD. I understand there is no charge for the testing. However, there may be charges should your child need to follow-up with a physician.

Georgetown ISD may release the ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) results to my child's primary care physician, neurologist, GISD team physician, and/or other treating physician, as indicated below.

I understand that general information about the test data may be provided to my child's guidance counselor and teachers, for the purposes of providing temporary academic modifications, if necessary. No specifics about the injury will be discussed at any time without permission from the parents.

If you have any questions about the test or testing procedures please feel free to contact one of the Staff Athletic Trainers and they would be more than happy to assist you in any way possible.

GISD TEAM PHYSICIAN

Dr. James Bray, M.D.
Family Medicine/Sports Medicine Physician
Scott & White
603 W. University Ave.
Georgetown, TX 78626
Phone: (512) 509-9550

STUDENT-ATHLETE PRIMARY CARE PHYSICIAN

Name of Physician: _____
Name of Practice of Group: _____
Address of Physician: _____
Phone Number: _____

Name of parent or guardian: _____

Signature of parent or guardian: _____

Date: _____

Chad Hennessey, M.S. Ed., ATC, LAT
Athletic Trainer
Georgetown High School
Office: (512) 943-5000 ext 7200
E-Mail: hennesseyc@georgetownisd.org

Vanessa Morales, M.S., ATC, LAT, NASM-CES
Athletic Trainer
Georgetown High School
Office: (512) 943-5000 ext 7213
E-Mail: moralesv@georgetownisd.org

*For additional information regarding the ImPACT Concussion Test and its procedures please go to the Georgetown Athletic Training website at http://www.georgetownisd.org/ghs/trainers/parent_information.htm and scroll down to the section about concussions.

GEORGETOWN ISD STUDENT-ATHLETE EMERGENCY FORM

(This form is used in case of a medical emergency and will travel with your child)

Student Athlete's Name _____

(Last)

(First)

(MI)

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Mother/ Guardian

Father/Guardian

Mother/Guardian Father/Guardian

Cell Phone: _____

Mother/Guardian

Father/Guardian

Parent's/Guardian's Names _____

Mother/Guardian

Father/Guardian

I. Family physician _____ 2nd Choice _____

II. Insurance Co. Name _____ Policy/Group No. _____

Medical Alerts

I hereby authorize a representative of Georgetown ISD to refer the above student to the above physician or any other physician available in a medical emergency.

Parent's/Guardian's Signature _____ Date _____

Athlete's Grade: _____ (2011-12 School Year)

NON-PRESCRIPTION MEDICATION ACKNOWLEDGEMENT/ RELEASE FORM

The following non-prescription medications can be made available for all athletes as deemed necessary by the athletic trainer following the guidelines and / or directions of a team physician:

Cough drops, antihistamine tablets, non-aspirin pain relief (acetaminophen, ibuprofen),

anti-acid tablets, decongestant tablets, anti-diarrhea tablets,

electrolyte replacement tablets, electrolyte drinks (Gatorade, Powerade),

anti-fungal crème, hydrocortizone crème, antibiotic ointment, hydrogen peroxide

My child may NOT have any of the above medications that I have circled.

Parent's/ Guardian's Signature

GEORGETOWN ISD STUDENT-ATHLETE EMERGENCY FORM

(This form is used in case of a medical emergency and will travel with your child)

Student Athlete's Name _____

(Last)

(First)

(MI)

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Mother/ Guardian

Father/Guardian

Mother/Guardian Father/Guardian

Cell Phone: _____

Mother/Guardian

Father/Guardian

Parent's/Guardian's Names _____

Mother/Guardian

Father/Guardian

I. Family physician _____ 2nd Choice _____

II. Insurance Co. Name _____ Policy/Group No. _____

Medical Alerts

I hereby authorize a representative of Georgetown ISD to refer the above student to the above physician or any other physician available in a medical emergency.

Parent's/Guardian's Signature _____ Date _____

Athlete's Grade: _____ (2011-12 School Year)

NON-PRESCRIPTION MEDICATION ACKNOWLEDGEMENT/ RELEASE FORM

The following non-prescription medications can be made available for all athletes as deemed necessary by the athletic trainer following the guidelines and / or directions of a team physician:

Cough drops, antihistamine tablets, non-aspirin pain relief (acetaminophen, ibuprofen),

anti-acid tablets, decongestant tablets, anti-diarrhea tablets,

electrolyte replacement tablets, electrolyte drinks (Gatorade, Powerade),

anti-fungal crème, hydrocortizone crème, antibiotic ointment, hydrogen peroxide

My child may NOT have any of the above medications that I have circled.

Parent's/ Guardian's Signature