

Fall	Winter	Spring
Volleyball	Girls Basketball	Track and Field
Cross Country	Boys Basketball	Softball
Girls Soccer	Wrestling	Girls Tennis
Boys Golf	Cheerleading	Girls Golf
Boys Tennis	Equestrian (all year)	Baseball
Football		Boys Soccer
Cheerleading		

Office Use Only	
_____	Insurance
_____	Athletic Code
_____	Parent Permission
_____	Injury Risk Disclaimer
_____	FB Warning Waiver
_____	Physical- Exp. _____
_____	WR/WT Permit
_____	Medical Release
_____	ASB Card
_____	Participation Fee
_____	2.0 GPA

### ATHLETIC PARTICIPATION PACKET

Student Name: \_\_\_\_\_ Birth date: \_\_\_\_\_  
 Student Number: \_\_\_\_\_ Grade: \_\_\_\_\_  
 School:  WHS  EHS  CCMS  JMS  Other \_\_\_\_\_  
 Previous School: \_\_\_\_\_  
 Street Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Father's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Work Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Custodial parent (if applicable): \_\_\_\_\_

(Parent to complete the above information.)

### INSURANCE STATUS FORM

I approve of my son's/daughter's participation in: *(name of sport(s))*

Fall	Winter	Spring

which includes the regularly scheduled trips as a team member. I realize there is a certain degree of danger of physical injury inherent in sports participation although it is understood that every effort will be made to minimize such danger through proper coaching and training techniques. I accept full responsibility for the cost of treatment for any injury which he/she may suffer while taking part in the program.

Accident insurance is required for all students participating in our sports program. Insurance is available through the school if you do not have a plan of your own or would like to supplement your own coverage. The rates vary depending on the coverage you choose and/or need. Accidental dental coverage is available for a full year.

**We have adequate medical insurance, which will be kept in force through each sport season.**

\_\_\_\_\_ *Insurance Company* \_\_\_\_\_ *Policy Number*

**We have adequate accidental dental insurance, which will be kept in force through each sport season.**

\_\_\_\_\_ *Insurance Company* \_\_\_\_\_ *Policy Number*

**Parent/Guardian Signature** \_\_\_\_\_

## Student/Parent Activities Pledge and Information Card

STUDENT NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ SEX \_\_\_\_\_

ACTIVITY \_\_\_\_\_

STUDENT ACTIVITY PLEDGE (*See handbook, Activities Code, for further description*)

1. Maintain scholastic eligibility
2. Abide by Activities Code
3. Be adequately insured
4. Take proper care of equipment
5. Be a credit to your school
6. Promote good sportsmanship
7. Purchase an ASB card to support activities
8. Pay user fee prior to turn out.

**Student Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I hereby grant permission for my son/daughter to participate in the above activities for the \_\_\_\_\_ school year. I am aware of, and accept the expectations for athletes as outlined in the Athletic/Activities Handbook, and agree to promote the Activities Code.

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

### STUDENT: READ, INITIAL AND SIGN

I am aware that playing or practicing to play/participate in any sport can be a dangerous activity involving **MANY RISKS OF INJURY**. I understand that the dangers and risks of playing or practicing to play/participate in sports include but are not limited to death, serious neck and spinal injuries (which may result in complete or partial paralysis), brain damage, serious injury to virtually all internal organs, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the muscular skeletal system, and serious injury or impairment to other aspects of my body, general health and well-being. I understand that the dangers and risks of playing or practicing to play/participate in sports may result not only in serious injury, but in a serious impairment of my future abilities to earn a living, to engage in other business, social and recreational activities, and generally to enjoy life.

Because of the dangers of participating in sports, I recognize the importance of following coaches' instructions regarding playing techniques, training and other team rules, etc., and to agree to obey such instructions.

**Student Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### PARENT/GUARDIAN: READ, INITIAL AND SIGN

As the parent/legal guardian of \_\_\_\_\_, I have read Washougal School District's warning and understand, its terms. I understand that all sports can involve many RISKS OF INJURY, including, but not limited to, those risks outlined.

**Signature of Parent/ Legal Guardian:** \_\_\_\_\_ **Date :** \_\_\_\_\_

The following to be completed only if sport is **Football, Wrestling, Baseball, or Track & Field:**  
I specifically acknowledge that \_\_\_\_\_

\_\_\_\_\_ *[indicate sport(s)]*  
is a **VIOLENT CONTACT or HIGH RISK SPORT(S)** involving even greater risk of injury than other sports.

\_\_\_\_\_  
*(Parent/guardian initial)*

Completed Doctors Clinic Physical – Date: \_\_\_\_\_

Washington Interscholastic Activities Association (WIAA)  
PREPARTICIPATION HISTORY AND PHYSICAL EXAMINATION

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Exam Date \_\_\_\_\_

Address \_\_\_\_\_

Phone ( ) \_\_\_\_\_ Sport(s) \_\_\_\_\_  
*City* *Zip*

**HISTORY**

- |     | Yes | No                       |   |
|-----|-----|--------------------------|---|
| 1.  | a.  | <input type="checkbox"/> | <input type="checkbox"/> Have you had any illness/injury recently, or do you have an illness/injury now?                    |
|     | b.  | <input type="checkbox"/> | <input type="checkbox"/> Have you had a medical problem, illness or injury since your last exam?                            |
|     | c.  | <input type="checkbox"/> | <input type="checkbox"/> Do you have any chronic or recurrent illness?  |
|     | d.  | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had any illness lasting more than a week?  |
|     | e.  | <input type="checkbox"/> | <input type="checkbox"/> Have you ever been hospitalized overnight?   |
|     | f.  | <input type="checkbox"/> | <input type="checkbox"/> Have you had any surgery other than tonsillectomy?   |
|     | g.  | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had any injuries requiring treatment by a physician?                                 |
|     | h.  | <input type="checkbox"/> | <input type="checkbox"/> Do you have any organ missing other than tonsils (appendix, eye, kidney, testicle, etc.)?          |
| 2.  |     | <input type="checkbox"/> | <input type="checkbox"/> Are you presently taking ANY medications (including birth control pills, vitamins, aspirin, etc.)? |
| 3.  |     | <input type="checkbox"/> | <input type="checkbox"/> Do you have ANY allergies (medicine, bees, foods, or other factors)?                               |
| 4.  | a.  | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had chest pain, dizziness, fainting, passing out during or after exercise?           |
|     | b.  | <input type="checkbox"/> | <input type="checkbox"/> Do you tire more easily or quickly than your friends during exercise?                              |
|     | c.  | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had any problem with your blood pressure or your heart?                              |
|     | d.  | <input type="checkbox"/> | <input type="checkbox"/> Have any close relatives had heart problems, heart attack or sudden death before they were age 50? |
| 5.  |     | <input type="checkbox"/> | <input type="checkbox"/> Do you have any skin problems (acne, itching, rashes, etc.)?                                       |
| 6.  | a.  | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had fainting, convulsions, seizures, or severe dizziness?                            |
|     | b.  | <input type="checkbox"/> | <input type="checkbox"/> Do you have frequent severe headaches?   |
|     | c.  | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had a “stinger” or “burner” or “pinched nerve”?                                      |
|     | d.  | <input type="checkbox"/> | <input type="checkbox"/> Have you ever been “knocked out” or “passed out”?  |
|     | e.  | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had a neck or head injury?   |
| 7.  |     | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had heat exhaustion, heat stroke, heat cramps or similar heat-related problems?      |
| 8.  |     | <input type="checkbox"/> | <input type="checkbox"/> Have you had asthma, or trouble breathing, or cough during or after exercise?                      |
| 9.  | a.  | <input type="checkbox"/> | <input type="checkbox"/> Do you wear eyeglasses, contact lenses or protective eye wear?                                     |
|     | b.  | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had any problem with your eyes or vision?  |
| 10. |     | <input type="checkbox"/> | <input type="checkbox"/> Do you wear any dental appliance such as braces, bridge, plate, retainer?                          |
| 11. | a.  | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had a knee injury?   |
|     | b.  | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had an ankle injury?   |
|     | c.  | <input type="checkbox"/> | <input type="checkbox"/> Have you ever injured any other joint (shoulder, wrist, fingers, etc.)?                            |
|     | d.  | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had a broken bone (fracture)?  |
|     | e.  | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had a cast, splint, or had to use crutches?  |
|     | f.  | <input type="checkbox"/> | <input type="checkbox"/> Must you use special equipment for competition (pads, braces, neck roll, etc.)?                    |
| 12. |     | <input type="checkbox"/> | <input type="checkbox"/> Has it been more than five years since your last tetanus booster shot?                             |
| 13. |     | <input type="checkbox"/> | <input type="checkbox"/> Are you worried about your weight?   |
| 14. |     | <input type="checkbox"/> | <input type="checkbox"/> FEMALES: Have you any menstrual problems?  |
| 15. |     | <input type="checkbox"/> | <input type="checkbox"/> Have you any medical concerns about participating in your sport?                                   |

*(Athlete should not write below this line)*

**EXAMINER’S COMMENTS ON ALL “YES” ANSWERS** (refer to question number):

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# PHYSICAL EXAMINATION

Optional

Name \_\_\_\_\_  
 Age \_\_\_\_\_ Pulse \_\_\_\_\_  
 Height \_\_\_\_\_ Blood Pressure \_\_\_\_\_  
 Weight \_\_\_\_\_ Visual Acuity: Left 20/ \_\_\_\_\_ Right 20/ \_\_\_\_\_

Urinalysis:  
  
 Body Fat %:  
  
 HCT:  
  
 EST VO2 Max:  
  
 Audiometry:

**Normal**

- 1. Head
- 2. Eyes (pupils), ENT
- 3. Teeth
- 4. Chest
- 5. Lungs
- 6. Heart
- 7. Abdomen
- 8. Genitalia
- 9. Neuralgic
- 10. Skin
- 11. Physical Maturity
- 12. Spine, Back
- 13. Shoulders, Upper extremities
- 14. Lower extremities

**Abnormal**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
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- \_\_\_\_\_
- \_\_\_\_\_

- Assessment:**     Full participation  
                           Limited participation (*describe limitations, restrictions*):  
                           Participation contraindicated (*list reason*):

\_\_\_\_\_

\_\_\_\_\_

**ATTENTION WRESTLERS! If applicable:**  
**Wrestling Weight Recommendations: I recommend that the student designated above should not be allowed to wrestle any weight less than the indicated classification circled herewith:**

<b>Junior</b>	78	85	90	95	100	105	110	115	120	125	130	137	145	154	164	175	210	275
<b>High</b>																		
<b>High School</b>	103	112	119	125	130	135	140	145	152	160	171	189	215	275				

**Note: Contestants will wrestle "scratch" weight throughout the entire season. There will be no weight allowance.**

**Unlimited must weigh over 190.**

Date \_\_\_\_\_

Examiner's Signature \_\_\_\_\_

Examiner's Phone (    ) \_\_\_\_\_

Examiner's Name Printed \_\_\_\_\_



## WASHOUGAL HIGH SCHOOL ATHLETICS

### Concussion Information Sheet

A concussion is a brain injury and all brain injuries are serious. They are caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, **all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly.** In other words, even a “ding” or a bump on the head can be serious. You can’t see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

<b>Symptoms may include one or more of the following:</b>	
<ul style="list-style-type: none"> <li>• Headaches</li> <li>• “Pressure in head”</li> <li>• Nausea or vomiting</li> <li>• Neck pain</li> <li>• Balance problems or dizziness</li> <li>• Blurred, double, or fuzzy vision</li> <li>• Sensitivity to light or noise</li> <li>• Feeling sluggish or slowed down</li> <li>• Feeling foggy or groggy</li> <li>• Drowsiness</li> <li>• Change in sleep patterns</li> </ul>	<ul style="list-style-type: none"> <li>• Amnesia</li> <li>• “Don’t feel right”</li> <li>• Fatigue or low energy</li> <li>• Sadness</li> <li>• Nervousness or anxiety</li> <li>• Irritability</li> <li>• More emotional</li> <li>• Confusion</li> <li>• Concentration or memory problems (forgetting game plays)</li> <li>• Repeating the same question/comment</li> </ul>

<b>Signs observed by teammates, parents and coaches include:</b>
<ul style="list-style-type: none"> <li>• Appears dazed</li> <li>• Vacant facial expression</li> <li>• Confused about assignment</li> <li>• Forgets plays</li> <li>• Is unsure of game, score, or opponent</li> <li>• Moves clumsily or displays incoordination</li> <li>• Answers questions slowly</li> <li>• Slurred speech</li> <li>• Shows behavior or personality changes</li> <li>• Can’t recall events prior to hit</li> <li>• Can’t recall events after hit</li> <li>• Seizures or convulsions</li> <li>• Any change in typical behavior or personality</li> <li>• Loses consciousness</li> </ul>

**What can happen if my child keeps on playing with a concussion or returns to soon?**

# WASHOUGAL HIGH SCHOOL ATHLETICS

## Concussion Information Sheet

Athletes with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one. This can lead to prolonged recovery, or even to severe brain swelling (second impact syndrome) with devastating and even fatal consequences. It is well known that adolescent or teenage athlete will often under report symptoms of injuries. And concussions are no different. As a result, education of administrators, coaches, parents and students is the key for student-athlete's safety.

### **If you think your child has suffered a concussion**

Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear, without medical clearance. Close observation of the athlete should continue for several hours. The new "Zackery Lystedt Law" in Washington now requires the consistent and uniform implementation of long and well-established return to play concussion guidelines that have been recommended for several years:

"a youth athlete who is suspected of sustaining a concussion or head injury in a practice or game shall be removed from competition at that time"

and

"...may not return to play until the athlete is evaluated by a licensed health care provider trained in the evaluation and management of concussion and received written clearance to return to play from that health care provider".

You should also inform your child's coach if you think that your child may have a concussion Remember its better to miss one game than miss the whole season. And when in doubt, the athlete sits out.

For current and up-to-date information on concussions you can go to:

<http://www.cdc.gov/ConcussionInYouthSports/>

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Student-athlete Name Printed

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Student-athlete Signature

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Date

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Parent or Legal Guardian Printed

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Parent or Legal Guardian Signature

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Date