AURORA PUBLIC SCHOOLS ATHLETICS AND ACTIVITIES
ATHLETIC REGISTRATION

Student name:_____ **Grade:**_____ **Date of Birth** ___/___/___
(Last) (First)

Gender: [ ] Female [ ] Male

Fall sport: _____

Winter sport:_____

Spring sport:_____

Address: _____
(Street)

_____
(City) (State) (Zip)

Home Phone: _____ Mobile/Cell Phone: _____
(xxx) xxx - xxxx (xxx) xxx - xxxx

Father/Guardian Name:_____ Phone:_____
(Last) (First) (xxx) xxx - xxxx

Mother/Guardian Name:_____ Phone:_____
(Last) (First) (xxx) xxx - xxxx

School you are attending this year_____ School Year_____

Are you transferring schools? ☐ Yes ☐ No If yes, school attended last year:_____

PARENT/GUARDIAN PERMISSION

I/We understand that there is a risk of (student) _____ being injured that is inherent in all sports. I/We realize the risk of injury may be severe, including, but not limited to, fractures, brain injuries, paralysis, or even death, and we release and discharge Aurora Public Schools, their agents, employees, and directors from any and all liability for such injury resulting, directly or indirectly, from such participation. We further recognize and agree that Aurora Public Schools do not waive their defenses provided by the Colorado Governmental Immunity Act.

I hereby give my permission for (student)_____ to participate in the Aurora Public Schools Athletic Program.

_____
STUDENT NAME SCHOOL GRADE

_____
PARENT/GUARDIAN SIGNATURE DATE

In case of an accident or serious illness, please provide the name and telephone number of a person who can be contacted at a time when the parent(s) or guardian(s) cannot be reached.

Emergency contact name:_____ Phone: _____

For Office Use Only	Physical Exam Date:_____	Parent/Guardian Permit_____	Eligible: ☐ Yes ☐ No
	Insurance:_____	Fee Paid:_____	Other: _____

STUDENT ELIGIBILITY INFORMATION FORM
AND
ANTI-HAZING POLICY

ATHLETICS/ACTIVITIES

I hereby give my consent for (student) _____ to compete in athletics for (school) _____ in APS and Colorado High School Activities Association (CHSAA) approved sports, except as noted on the Physical Examination and/or Parent Permit Form. I have read and understand the general guidelines for eligibility as outlined in the CHSAA Competitor's Brochure (found at www.CHSAANow.com)

Parent or Guardian Signature_____ **Date** _____

Student/Athlete Signature_____ **Date**_____

No student shall represent their school in interschool athletics until there is a statement on file with the superintendent or principal signed by his/her parent or legal guardian and a signed physical form certifying that he/she has passed an adequate physical examination within the past year, noting that in the opinion of the examining physician, physician's assistant, nurse practitioner or a certified/registered chiropractor, (DC, Spc.) is physically fit to participate in high school athletics; that student has the consent of his/her parents or legal guardian to participate; and, the parent and participant have read, and understand and agree to CHSAA guidelines for eligibility.

APS/CHSAA ANTI-HAZING POLICY

Students at any APS High School earn the privilege to participate in our numerous extra-and co-curricular activities through the consistency of their efforts and the quality of their performance. Student initiations, hazing, personal servitude, and similar student-to-student, seniority-based activities are specifically prohibited by State Law, Board of Education Policy, and the Student Code of Conduct. Violations of this directive shall result in severe disciplinary action by the school administration and may result in the loss and privilege to participate in our extra- and co-curricular activities.

APS and CHSAA strictly **prohibit** bullying, hazing, intimidation, or threats. I understand that hazing of any type is not permitted in any APS or CHSAA sanctioned activity. I will not engage in any of the prohibited conduct. I further understand that it is my responsibility to immediately report any acts of hazing that I become aware of to a sponsor, teacher, counselor, school support staff, coach or administrator in my school.

By signing this acknowledgement, I affirm my responsibility to prevent and report hazing. I also understand that any violation of this could result in school or team consequences that could include dismissal from the activity or further disciplinary consequences and/or referral to law enforcement.

Student/Athlete Signature_____ **Date**_____

AURORA PUBLIC SCHOOLS ATHLETICS AND ACTIVITIES INSURANCE WAIVER

TO PARENTS/GUARDIANS OF ALL STUDENT ATHLETES:

Although participation in interscholastic athletics is completely voluntary, by its nature, many forms of athletic competition may result in violent physical contact among players, the use of equipment which may result in accidents, strenuous physical exertion, and numerous other exposures to risk of injury. Participation in any interscholastic activity includes a risk of injury which may range in severity from minor to long-term catastrophic injury or even death. Although serious injuries are not common in supervised school athletic programs, it is impossible to eliminate this risk. Students and parents must assess the risks involved in such participation and make their choice to participate in spite of those risks. No amount of instruction, precaution, or supervision will totally eliminate all risk of injury. By granting permission for your student to participate in athletic competition, you, the parent or guardian, acknowledge that such risk exists.

By signing this statement, I/we release Aurora Public Schools of financial responsibility in case of accident/injury to my son/daughter while participating in interscholastic activities. I fully understand Aurora Public Schools does not provide accident or health insurance coverage for my son/daughter while participating in interscholastic activities. However, accident insurance is made available by the school district through an authorized agent at my cost. I further understand that it is my responsibility to provide health/accident insurance coverage for my son/daughter.

OPTIONS (Please check one and sign below):

☐ I have current health insurance for my student athlete. Insurance provider:_____

☐ I am purchasing student accident insurance for my student through the authorized agent for the school district. Information on student accident insurance can be obtained from your school or by visiting http://risk.aurorak12.org/insurance-certificates/student-insurance/

☐ My student is covered by Military insurance. Identification number:_____

☐ I do not have accident or health insurance coverage for my student. I fully understand that I am responsible for any medical bills related to his/her participation in interscholastic activities while representing Aurora Public Schools.

_____ _____

Parent/Guardian Signature Date

**This form is valid for the entire school year for which it is signed. Please promptly notify the athletic administration at your student's school of any changes in coverage that may occur during the school year.

TRANSPORTATION AWARENESS

Consent and Release

The Aurora Public School District (the "District") provides District transportation for students to and from a great many activities, events, matches and games. However, the District is unable to provide District transportation in all circumstances and to all events. When District transportation is not available, it is the student's/parent's/guardian's responsibility to provide or arrange for their student's transportation to and from the event.

When District transportation is not available and other alternative forms of transportation are utilized, the District cannot and does not assume any responsibility for the safety, training of drivers, condition of vehicles, adequacy for the use or purpose intended or any other matters related to any non-District transportation.

Therefore, we, the parent/guardian and student, hereby acknowledge, agree and understand that the District does not insure, endorse, approve or sponsor any form of non-District transportation, whether by parents, students or otherwise, to and from District off-campus activities or events. We further acknowledge it is our responsibility to provide or arrange for our/my child's transportation to District events when District transportation is not available. As such we consent to our child's use of alternative means of transportation, including private vehicles driven by us, another adult, another student, and, if applicable, consent to our child's use of vehicle to transport himself/herself to off-campus events.

ATHLETIC REGISTRATION/PARTICIPATION SIGNATURE PAGE

Signing this form states that you understand the athletic guidelines, philosophy, and rules for participation in any Aurora Public Schools Athletic Activity Program and the consequences of any violation of said rules.

Student Initials _____ Parent Initials _____

ATHLETIC/ACTIVITIES CODE OF CONDUCT

We have read and understand the philosophy with regard to the academic and citizenship requirements of the athletic/activity programs. My daughter/son is responsible for their actions year round. Any violation of these rules may result in suspension or expulsion from the activities/athletic programs.

Student Initials _____ Parent Initials _____

ATHLETIC CHEMICAL AWARENESS CONTRACT

I have read and recognize the use of mood-altering chemicals as a significant health problem for many adolescents, resulting in negative effects on behavior, learning and the total development of each individual. I also understand the rules and penalties for violating Aurora Public Schools Chemical Contract.

Student Initials _____ Parent Initials _____

INITIATION and HAZING DIRECTIVE

I have read and understand the APS/CHSAA security directive on initiations and hazing. I am aware of its requirements and I understand that any violation of these rules and regulations will subject me to appropriate and swift action taken by the High School administration including but not limited to removal from the team, suspension and expulsion.

Student Initials _____ Parent Initials _____

TRANSPORTATION AWARENESS (Consent and Release)

We hereby waive, release, discharge and agree to hold harmless and indemnify the District, its agents, employees, insurers and Board of Education, from any claim, cause of action, damage, injury, or demand of any nature, including bodily injury, property damage or death, arising from or sustained during or as a result of my/our child's utilization of or participation in any non-District transportation, whether furnished by us, our student, another student, another adult, or otherwise.

Student Initials _____ Parent Initials _____

APS/CHSAA SPORTSMANSHIP/SPECTATOR RESPECT PLEDGE

I will focus my actions as a student participant on respecting all opponents participants, coaches, sponsors, parents, fans and officials. I believe that by demonstrating respect for all people involved in my activity, I am a catalyst for positive interaction among participants in interscholastic activities and athletics. By taking this pledge, I accept the responsibility of serving as a role model for all students in my community."

Student Initials _____ Parent Initials _____

ATHLETIC PARTICIPATION FEE

Students shall remit a participation fee of $60.00 for each sport before the first contest. In order to avoid a financial burden on a family, APS offers the following **FAMILY PLAN** for the payment of athletic fees. The maximum amount to be paid by a family with one athlete in high school shall be $120.00. The maximum amount to be paid by a family with two or more athletes in high school will be limited to $180.00 per school year. When two or more students from the same family participate in a sport during the same season, the maximum amount to be paid during that season shall be limited to $90.00.

I have read and understand the information contained in the above guidelines. By signing here you agree to the above statements.

Student Signature	Print Student Name	Date
Parent/Guardian Signature	Print Parent/Guardian Name	Date

Medical Pre-Participation Physical Evaluation

This Page for Physician Only (Parent or physician can retain for records)

HISTORY FORM

(Note: Front page is to be filled out by the student/athlete and parent prior to seeing the physician)

Athlete Name _____ Date of birth _____

Sex _____ Age _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

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

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. 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.

This form approved and provided by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.

Parent/guardian completes page 1
(on the reverse side)
Give page 1 to Healthcare Provider

Healthcare Provider completes
and signs Page 3 →

Parent/guardian completes
and signs page 4
Submit pages 3 & 4 to the school

Fold crease and separate page here

PHYSICAL EXAMINATION FORM

(This page is to be completed by the Physician or Certified Medical Provider. This page should then be turned into the school)

Date of Exam ____/____/____
Month Day Year
(Exam is good for one calendar year from this date)

Student/Athlete Name_____ Date of birth_____

Grade _____

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

Describe any significant medical or health problems (asthma, diabetes, epilepsy, hearing condition, kidney problems, etc.) that could affect the student/athlete's participation

_____

☐ **Cleared for all sports without restriction**

☐ **Cleared for all sports without restriction with recommendations for further evaluation or treatment for** _____

_____

☐ **Not cleared**

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason_____Recommendations _____

_____

I have examined the above-named student and completed the pre-participation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of MD/DO, PA, NP, DC-SPC# (print/type)_____ Date _____

Address_____ Phone _____

Signature of MD/DO, PA, NP, DC-SPC#_____

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Consent for Emergency Treatment and Medical Information

This information is confidential and is intended for use by authorized school officials only

Student name:_____
(Last Name) (First Name) (Middle Initial)

Birthdate:____/____/____ Gender: Female Male Grade:_____

Fall Sport_____ Winter Sport_____ Spring Sport_____

Father/Guardian

Name:_____

Home Phone:_____

Mobile Phone:_____

Work Phone:_____

Email_____

Mother/Guardian

Name:_____

Home Phone:_____

Mobile Phone:_____

Work Phone:_____

Email_____

Emergency Contact (if parent/guardian is not available)

Contact Name:_____ Contact Phone:_____

Relationship to Student_____ Alt Phone:_____

Student Health Information

Primary Care Physician:_____ Physician Phone:_____

Insurance Company:_____ Policy #_____

Please list any medical/health problems (asthma, diabetes, epilepsy, heart conditions, seizures, etc)

_____

History of Concussion - (Please list dates)_____

Please list any known allergies (including medications, food, latex, stings, etc...)

_____

Medications taken daily_____

Hospital (preference)_____

In consideration of my child's opportunity to participate in interscholastic activities, I hereby consent to emergency medical treatment, hospitalization or other necessary health care treatment, including first aid, diagnostic procedures and medical treatment, as may be necessary for the welfare of my child, by a physician, qualified nurse, certified athletic trainer, and/or hospital in the event of injury or illness during all periods of time in which the student is away from his/her legal residence as a member of an interscholastic activity team or group, and hereby waive on behalf of myself and my child any liability of the school district, any agents or employees, arising out of such medical treatment. I also give permission to the Certified Athletic Trainer to release athletic injury information about my student to the appropriate medical staff and necessary APS school personnel in compliance with HIPPA (Health Insurance Portability and Accountability Act) Regulations.

_____ _____

Parent/Guardian Signature **Date**

*This information page is valid for 1 school-year. If any changes in the above information occur, a new page must be completed by the parent/guardian and returned to the athletic department as soon as possible.