

Las Virgenes Unified School District
AGOURA HIGH SCHOOL
ACTIVITY/ATHLETIC CERTIFICATE

PHYSICAL DATE: _____
GRADE: _____
Activity _____

Spring _____

Winter _____

Fall _____

Summer _____
OFFICE USE ONLY

STUDENT (Last, First): _____

Student's Name _____,
(Last) (First)

Address: _____ City & Zip _____

Home Phone: _____ Parent Cell Phone: _____ Parent Name: _____

PARENT OR GUARDIAN'S PERMIT

I hereby give my consent for the above named student to compete in the Agoura High School approved activity program (athletics, Spirit Team, forensics, music, drama, etc.) and travel with the school representative on authorized school trips. I, the undersigned, hereby release and discharge the Las Virgenes Unified School District, officers, employees, agents, servants, and volunteers (herein collectively referred to as "District") from all liability arising out of or in connection with the above described activity or all liabilities associated with any and all claims related to such activity that may be filed on behalf of or for the above named minor. For the purposes of this agreement, liability means all claims, demands, losses, caused of action, suits or judgments of any and every kind that I, my heirs, executors, administrators or assignees may have against the District, or that any other person or entity may have against the District because of any death, personal injury or illness, or because of any loss or damage to property that occurs during the above described activity and that results from any cause other than the negligence of the District.

Date: _____ Signature of Parent/Guardian: _____

CONSENT FOR EMERGENCY TREATMENT

I hereby give permission to a physician to administer emergency treatment to the above named student. In the event of any illness or injury, I hereby consent to whatever x-ray, examination, anesthetic, medical, dental or surgical diagnosis or treatment and hospital care from a licensed physician and/or surgeon as deemed necessary for the safety and welfare of my child. It is understood that the resulting expenses will be the responsibility of the parent(s), guardian or participant.

Date: _____ Signature of Parent/Guardian: _____

INSURANCE CERTIFICATION (A OR B MUST BE COMPLETED!)

(THE DISTRICT/SCHOOL DOES NOT PROVIDE HEALTH/ACCIDENT INSURANCE.) I hereby certify that the above named student is covered by accident insurance which provides protection for accidental bodily injury and for accidental death as required by Education code Sections 32220-24 for participation in approved school activities during the school year:

A. CIF Endorsed School Insurance Plan

- a. ___ "24 Hour Plan" or "School Time Plan" (does not include football).
- b. ___ "Tackle Football Plan" (covers football only)
- c. Medical brochures and forms are available in the AAC or www.myers-stevens.com and must be returned with the completed athletic forms.

B. Health Insurance Membership # _____ Group # _____

Name & Address of Carrier: _____

Date: _____ Signature of Parent/Guardian: _____

PARENT WAIVER TO RELEASE UNOFFICIAL TRANSCRIPTS

I hereby authorize the release of any unofficial transcripts of the above named student/athlete to any college/university requesting the information.

Date: _____ Signature of Parent/Guardian: _____

STUDENT CERTIFICATION

I AGREE TO ABIDE BY THE California Interscholastic Federation, League and school rules of eligibility and conduct. I am not a member of a fraternity, unsponsored club or unauthorized secret society as described in the Education code and California Interscholastic Federation handbook, nor will I join one.

Date: _____ Signature of Student: _____

C.I.F. ATHLETIC PARTICIPATION HEALTH FORM
LAS VIRGENES UNIFIED SCHOOL DISTRICT
HEALTH SERVICES

STUDENT INFORMATION – To be completed by student – Parent/Guardian signature required

Last name:	First name:
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HISTORY: (check yes or no)

YES	NO	ILLNESS	YES	NO	ILLNESS	YES	NO	ILLNESS
		Allergy/Asthma			Glasses/Contacts			Mononucleosis
		Arthritis			Heart Murmur			Mumps
		Chicken Pox			Hepatitis			Pneumonia
		Concussion			Hernia			Polio
		Diabetes			Kidney problems			Rheumatic fever
		Epilepsy/Seizures			Measles			Tuberculosis
		Fainting (frequent)			Migraine headache			Whooping cough

1. Please note any other medical information that school personnel may need _____

ORIGINAL MUST BE RETURNED TO SCHOOL – NO COPIES

PHYSICIAN INFORMATION – To be completed by Physician or Nurse Practitioner only.

Weight:	B.P.	Pulse:
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Code: 0 – Negative X = Positive NE: = No Examination

Ear, Nose, Throat		8. Musculoskeletal evaluation	
Eyes – pupil equal reactive		8.1 Flexibility/stability of joints	
- Symmetry of eye movement		- Gait - hand	
Dental – missing teeth		- Knee bend	
- chipped teeth		8.2 Spine: Scoliosis	
- removable teeth		8.3 Swelling of any joint	
- orthodontia		8.4 Muscular weakness	
Lungs		8.5 Atrophy	
Heart		- Thigh -shoulder girdle	
Abdomen		- Calf -arm	
Hernia		9. In coordination/loss of balance	

Additional findings, comments and /or recommendations _____

“I certify that I have on this date examined this student and that, on the basis of the exam 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.”

IF STUDENT IS NOT MEDICALLY FIT TO PARTICIPATE IN ATHLETICS OR IF THERE ARE EXCEPTIONS TO THE ABOVE STATEMENT, EXAMINING PHYSICIAN SHOULD INDICATE ABOVE.

Signature of Examining Physician: _____ Phone: _____

Print Name: _____ Date of Physical: _____ Date: _____

(Good for one calendar year)

*STAMP REQUIRED HERE

Please note: Physical done by school doctors at the annual school-wide physicals do not replace your child’s regular annual check-up with your primary care physician.

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Consent to Test Form

I understand fully that my performance as a participant and the reputation of my school are dependent, in part, on my conduct as an individual. I hereby agree to accept and abide by the standards, rules and regulations set forth by the LVUSD Board of Education and the sponsors for the activity in which I participate.

I agree to participate in the Random Student Drug Testing pool. I agree to allow qualified LVUSD employees, or a qualified laboratory, to conduct a test on a urine specimen which I provide on-site for drugs if my name is drawn from the random pool. I authorize the release of information concerning the results of such tests (i.e. positive or negative) to District personnel and, if I am at least 18 years old, to my parent/guardian listed below. If I am at least 18 years old, I also agree that the District may notify my parent/guardian listed below of the fact that I have undergone a random drug test.

I understand that I may be randomly drug tested throughout the remainder of the school year whether or not I have been previously tested. I also understand that I will remain a member of the pool even if the activity of which I am a part is over.

I understand that if I fail a drug test for the first time, I will be suspended from participation in student athletics for the remainder of the athletic activity season. If I am subsequently selected for testing and fail a drug test for the second time, I understand that I will be suspended from participation in student athletics for one calendar year from the date I am notified of my second failed drug test. If I am subsequently selected for testing and fail a drug test for the third time, I understand that I will be banned indefinitely from participation in all student athletics.

If I choose to remove myself from the selection pool I will fill out an Activity Drop Form and have it signed by my parent/guardian, my coach/advisor and the Athletic Assistant Principal. I understand that if I complete an Athletic Activity Drop Form and remove myself from the testing pool, I will not be eligible to participate in student athletics for one calendar year from the date I am officially dropped from the current athletic activity.

Student Name (please print)

Student ID number

Student Signature

Date

Parent/Guardian Name (please print)

Parent/Guardian Signature

Parent/Guardian Home Phone

Parent/Guardian Work Phone

I plan to participate in the following sports: _____

This form is to remain on file at the school site

**Las Virgenes Unified School District
Extracurricular/Co-Curricular Activities
Code of Conduct Parent and Student Signatures**

EXTRACURRICULAR/CO-CURRICULAR ACTIVITIES AFFECTED:

Interscholastic Athletics	Outdoor Education Counselors
Spirit Team	Newspaper production activities
Student Government	Yearbook production activities
Class Officers	Musical groups & auxiliary units*
Club Officers	Choral productions*
Competitive Speech Activities	Drama productions*
Comedy Sportz	Dance productions*

- **Mandatory** performance-based (graded) activities that are aligned to a course that satisfies the entrance requirements for admission to the California State University of California are **exempt** from the LVUSD Code of Conduct Contract.

I have read and fully understand and accept the conditions set forth in this Code of Conduct Contract.

Name of Student: _____
(Please print) **Last** **First**

School: _____ **Grade:** _____

Signature of Student: _____ **Date:** _____

Co-curricular activity or sport _____

Name of Parent: _____
(Please print) **Last** **First**

Signature of Parent: _____ **Date:** _____

Street: _____

City/Zip: _____

Home Tel. # _____ **Work Tel. #** _____

Cell # _____

The parent/student signature form must be turned into the Activities/Athletic Office prior to participation in any school activity.

This form is for Athletes ONLY

CIF Southern
Section
Academics * Integrity * Athletics

10932 Pine St.
Los Alamitos, CA 90720
562-493-9500 * Fax 562-493-6266

ATHLETE’S CODE OF ETHICS

Athletics is an integral part of the school’s total educational program. All school activities, curricular and extracurricular, in the classroom and on the playing field, must be congruent with the school’s stated goals and objectives established for the intellectual, physical, social, and moral development of its students. It is within this context that the following Code of Ethics is presented.

As an athlete, I understand that it is my responsibility to:

1. Place academic achievement as the highest priority.
2. Show respect for teammates, opponents, officials and coaches.
3. Respect the integrity and judgment of game officials.
4. Exhibit fair play, sportsmanship and proper conduct on and off the playing field.
5. Maintain a high level of safety/awareness.
6. Refrain from the use of profanity, vulgarity and other offensive language and gestures.
7. Adhere to the established rules and standards of the game to be played.
8. Respect all equipment and use it safely and appropriately.
9. Refrain from the use of alcohol, tobacco, illegal and non-prescriptive drugs, anabolic steroids or any substance to increase physical development or performance that is not approved by the United States Food and Drug Administration, Surgeon General of the Unites States or American Medical Association.
10. Know and follow all state, section and school athletic rules and regulations as they pertain to eligibility and sports participation.
11. Win with character; lose with dignity.

Athlete’s Name (printed)

School

Athlete’s Signature

Date

Parent’s Signature

Date

A copy of this form must be kept on file in the Athletic Director’s office at the local high school on an annual basis and the Principal’s Statement of compliance must be on file at the CIF Southern Section Office.

Las Virgenes Unified School District
VOLUNTARY PARTICIPATION FORM
ACKNOWLEDGMENT AND ASSUMPTION OF POTENTIAL RISK

I authorize my son/daughter, _____ to participate in the
(Please print)

District-sponsored activities of: athletics, cheerleading, and/or any other extra-curricular activities.

I understand and acknowledge that these activities, by their very nature, pose the potential risk of serious injury/illness to individuals who participate in such activities.

I understand and acknowledge that some of the injuries/illnesses which may result from participating in these activities include, but are not limited to, the following:

- | | |
|------------------------------|--------------------------|
| 1. Sprains/strains | 5. Paralysis |
| 2. Fractured bones | 6. Loss of eyesight |
| 3. Unconsciousness | 7. Communicable diseases |
| 4. Head and/or back injuries | 8. Death |
| | 9. Concussion |

I understand and acknowledge that participation in these activities is completely voluntary and as such is not required by the District for course credit or for completion of graduation requirements.

I understand and acknowledge that in order to participate in these activities, I and my son/daughter agree to assume liability and responsibility for any and all potential risks which may be associated with participation in such activities.

I understand, acknowledge, and agree that the District, its employees, officers, agents, or volunteers, shall not be liable for any injury/illness suffered by my son/daughter who is incident to, and/or associated with, preparing for and/or participating in this activity.

A signed VOLUNTARY PARTICIPATION FORM must be on file before a student will be allowed to participate. I acknowledge that I have carefully read this VOLUNTARY PARTICIPATION FORM and that I understand and agree to its terms.

PLEASE PRINT:

STUDENT NAME: _____

PARENT NAME: _____

Student Signature

Date

Parent/Guardian Signature

Date

Final Thoughts for Parents and Guardians:

It is well known that high school athletes will often not talk about signs of concussions, which is why this information sheet is so important to review with them. Teach your child to tell the coaching staff if he or she experiences such symptoms, or if he or she suspects that a teammate has had a concussion. You should also feel comfortable talking to the coaches or athletic trainer about possible concussion signs and symptoms that you may be seeing in your child.

I have read, understand, and agree to follow the above guidelines regarding concussions:

Student-Athlete Name(Last, First)

Student-Athlete Signature

Date

Parent or Guardian Name

Parent or Guardian Signature

Date

References:

- American Medical Society for Sports Medicine position statement: concussion in sport (2013)*
- Consensus statement on concussion in sport: the 4th International Conference on Concussion in Sport held in Zurich, November 2012*

<http://www.cdc.gov/concussion/HeadsUp/youth.html> *CIFSTATE.ORG CIF 5/201*

Keep Their Heart in the Game

Recognize the Warning Signs & Risk Factors of Sudden Cardiac Arrest (SCA)

Tell Your Coach and Consult Your Doctor if These Conditions are Present in Your Student-Athlete

Potential Indicators That SCA May Occur

- D Fainting or seizure, especially during or right after exercise
- D Fainting repeatedly or with excitement or startle
- D Excessive shortness of breath during exercise
- D Racing or fluttering heart palpitations or irregular heartbeat
- D Repeated dizziness or lightheadedness
- D Chest pain or discomfort with exercise
- D Excessive, unexpected fatigue during or after exercise

Factors That Increase the Risk of SCA

- D Family history of known heart abnormalities or sudden death before age 50
- D Specific family history of Long QT Syndrome, Brugada Syndrome, Hypertrophic Cardiomyopathy, or Arrhythmogenic Right Ventricular Dysplasia (ARVD)
- D Family members with unexplained fainting, seizures, drowning or near drowning or car accidents
- D Known structural heart abnormality, repaired or unrepaired
- D Use of drugs, such as cocaine, inhalants, "recreational" drugs, excessive energy drinks or performance-enhancing supplements

What is CIF doing to help protect student-athletes?

CIF amended its bylaws to include language that adds SCA training to coach certification and practice and game protocol that empowers coaches to remove from play a student-athlete who exhibits fainting—the number one warning sign of a potential heart condition. A student-athlete who has been removed from play after displaying signs or symptoms associated with SCA may not return to play until he or she is evaluated and cleared by a licensed health care provider. Parents, guardians and caregivers are urged to dialogue with student-athletes about their heart health and everyone associated with high school sports should be familiar with the cardiac chain of survival so they are prepared in the event of a cardiac emergency.

I have reviewed and understand the symptoms and warning signs of SCA and the new CIF protocol to incorporate SCA prevention strategies into my student's sports program.

STUDENT-ATHLETE SIGNATURE

PRINT STUDENT-ATHLETE'S NAME

DATE

PARENT/GUARDIAN SIGNATURE

PRINT PARENT/GUARDIAN'S NAME

DATE

For more information about Sudden Cardiac Arrest visit

California Interscholastic Federation
<http://www.cifstate.org>

Eric Paredes Save A Life Foundation
<http://www.epsavealife.org>

National Federation of High Schools
(20-minute training video)
<https://nfhslearn.com/courses/61032>



EMERGENCY CARD

(Separate form is required for each sport)

PLEASE PRINT CLEARLY

STUDENT'S NAME: _____ GRADE: _____

(LAST) (FIRST) SPORT/ACTIVITY: _____

ADDRESS: _____ BIRTHDATE: _____
(STREET)

(CITY) (ZIP CODE) MOTHER'S CELL # _____

Mother's Email Address: _____ FATHER'S CELL # _____

Father's Email Address: _____ FATHER'S WORK # _____

Student's Email Address: _____ HOME PHONE # _____

MOTHER'S NAME (PLEASE PRINT): _____

FATHER'S NAME (PLEASE PRINT): _____

EMERGENCY CONTACTS OTHER THAN PARENTS:

NAME _____ PHONE: (____) _____

NAME _____ PHONE: (____) _____

CONSENT FOR EMERGENCY TREATMENT:

I hereby give permission to a physician to administer emergency treatment to the above student.

*SIGNATURE OF PARENT/GUARDIAN: _____ Dated: _____

PHYSICIAN'S NAME: _____

PHYSICIAN'S PHONE: (____) _____

ANY KNOWN ALLERGIES OR PERTINENT HEALTH INFORMATION:

INSURANCE CERTIFICATION: INSURANCE COMPANY NAME: _____

INSURANCE CO. ADDRESS: _____

In the event of any illness or injury, I hereby consent to whatever x-ray, examination, anesthesia, medical, dental or surgical diagnosis or treatment and hospital care from a licensed physician and/or surgeon as deemed necessary for the safety and welfare of my child. It is understood that the resulting expenses will be the responsibility of the parent(s) or participant.

*SIGNATURE OF PARENT/GUARDIAN: _____ Dated: _____

OFFICE USE ONLY

<p>PHYSICAL EXPIRES DATE:</p> <p>_____</p>	<p>PRELIMINARY CLEARANCE:</p>	<p>FINAL CLEARANCE:</p>
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EMERGENCY CARD

(Separate form is required for each sport)

PLEASE PRINT CLEARLY

STUDENT'S NAME: _____ GRADE: _____

(LAST) (FIRST) SPORT/ACTIVITY: _____

ADDRESS: _____ BIRTHDATE: _____
(STREET)

(CITY) (ZIP CODE) MOTHER'S CELL # _____

Mother's Email Address: _____ FATHER'S CELL # _____

Father's Email Address: _____ FATHER'S WORK # _____

Student's Email Address: _____ HOME PHONE # _____

MOTHER'S NAME (PLEASE PRINT): _____

FATHER'S NAME (PLEASE PRINT): _____

EMERGENCY CONTACTS OTHER THAN PARENTS:

NAME _____ PHONE: (____) _____

NAME _____ PHONE: (____) _____

CONSENT FOR EMERGENCY TREATMENT:

I hereby give permission to a physician to administer emergency treatment to the above student.

*SIGNATURE OF PARENT/GUARDIAN: _____ Dated: _____

PHYSICIAN'S NAME: _____

PHYSICIAN'S PHONE: (____) _____

ANY KNOWN ALLERGIES OR PERTINENT HEALTH INFORMATION:

INSURANCE CERTIFICATION: INSURANCE COMPANY NAME: _____

INSURANCE CO. ADDRESS: _____

In the event of any illness or injury, I hereby consent to whatever x-ray, examination, anesthesia, medical, dental or surgical diagnosis or treatment and hospital care from a licensed physician and/or surgeon as deemed necessary for the safety and welfare of my child. It is understood that the resulting expenses will be the responsibility of the parent(s) or participant.

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OFFICE USE ONLY

<p>PHYSICAL EXPIRES DATE:</p> <p>_____</p>	<p>PRELIMINARY CLEARANCE:</p>	<p>FINAL CLEARANCE:</p>
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