

# 2018-2019

# Meadowbrook COLTS

## Student Athletic Handbook Participation Consent Form

I \_\_\_\_\_  
Athlete's Signature

and \_\_\_\_\_  
Parent/Guardian's Signature

have read the 2018-2019 Student Athletic Handbook and have been given  
parent/guardian consent to participate in the Meadowbrook Colts Athletic Program.

\_\_\_\_\_  
Date

**\*\* Only one parent/guardian signature above indicates that ALL parents/guardians of  
above athlete have read the student athletic handbook**

# 2018-2019

# Meadowbrook COLTS

## Parent/Guardian/Spectator Athletic Expectations Handbook Consent Form

Athletes Name: \_\_\_\_\_

I \_\_\_\_\_  
Parent/Guardian's Signature

have read the 2018-2019 Parent/Guardian/Spectator Athletic Expectations Handbook and have given consent to abide by all policies and procedures and understand that there will be consequences for any violation of the policies throughout the handbook.

\_\_\_\_\_  
Date

**\*\* Only one parent/guardian signature above indicates that ALL parents/guardians of above athlete have read the parent/guardian/spectator athletic expectations handbook**

## EMERGENCY MEDICAL AUTHORIZATION

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Student's Name \_\_\_\_\_ Birth date \_\_\_\_\_ Grade \_\_\_\_\_

Home Address \_\_\_\_\_ PO Box # \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Bus # \_\_\_\_\_ Other \_\_\_\_\_ Teacher \_\_\_\_\_

Student resides with (circle all that apply): mother father step-parent guardian other \_\_\_\_\_

If custody is involved, with whom is the student living? \_\_\_\_\_

List the names of those who have authority to make decisions in an emergency situation involving the student. Use first and last name. Indicate on the line to the left of the name the order in which you would like for contacts to be made (1<sup>st</sup>, 2<sup>nd</sup>, etc.).

\_\_\_\_ Mother: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

\_\_\_\_ Father: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

\_\_\_\_ Step-Parent: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

\_\_\_\_ Guardian: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

\_\_\_\_ Other relative/friend/child care provider: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

Siblings: Name: \_\_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_

Name: \_\_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_

Permission for participation in school fluoride program (K-5): Yes \_\_\_\_\_ No \_\_\_\_\_

Permission for picture publication (Newspaper, school articles, etc.): Yes \_\_\_\_\_ No \_\_\_\_\_

Permission for Tylenol (Grades 9-12) – In accordance with the Medication Policy 5330: Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, parent signature is required: \_\_\_\_\_

### COMPLETE ONLY PART 1 OR PART 2 BELOW (CONSENT OR REFUSAL FOR TREATMENT)

**PART 1**

**CONSENT FOR TREATMENT**

I hereby give consent for the following medical care providers and local hospital to be called.

Preferred Physician: \_\_\_\_\_

Office Phone: \_\_\_\_\_

Preferred Dentist: \_\_\_\_\_

Office Phone: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_

Office Phone: \_\_\_\_\_

**PART 2**

**REFUSAL TO CONSENT**

I do not give my consent for EMERGENCY MEDICAL TREATMENT of my child in the event of illness or injury requiring emergency treatment at the hospital. I wish the school to take the following action: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

The team Physician, trainer and coach may apply first aid treatment until the family doctor or parent can be contacted.

YES: \_\_\_\_\_ No: \_\_\_\_\_

We give out consent for coaches, trainer, and team physician to use their own judgment in securing medical aid and ambulance service in case the parent cannot be reached.

YES: \_\_\_\_\_ No: \_\_\_\_\_

If athlete is on special medication please indicate: \_\_\_\_\_

Reason: \_\_\_\_\_

Contact Lenses: Hard \_\_\_\_\_ Soft \_\_\_\_\_ None \_\_\_\_\_

MEDICAL HISTORY: Facts concerning the child's medical history including allergies, medications being taken at home and school, and any physical impairment of which a physician and/or school personnel should be alerted to: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In the event reasonable attempts to contact me or other emergency contacts have been unsuccessful, I hereby give my consent for any treatment deemed necessary by the preferred doctor indicated, or by another licensed physician or dentist, and the transfer of my child to any hospital reasonably accessible.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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*ROLLING HILLS LOCAL SCHOOL DISTRICT  
ATHLETIC DEPARTMENT  
PHONE NO. 740-685-5645*

*DEAR PARENTS:*

*Proper and adequate insurance for our athletes is a major concern of the Administration and Athletic Dept. of the Rolling Hills Local School District. The parent or guardian must designate some type of insurance coverage for the athlete if he or she is to be eligible to participate or practice.*

*If you do check personal responsibility, we highly advise that you check your personal insurance program for the following details:*

- 1. Are x-rays, emergency rooms, personal doctor's office calls or ambulance costs covered by your insurance plan?*
- 2. Is there a deductible clause to your insurance plan?*
- 3. Is your son or daughter covered if he or she is participating in an interscholastic sport?*

*The Ohio High School Athletic Association provides a blanket policy for all athletes for serious injuries from \$5,000.00 to \$10,000.00.*

*If you have any questions, please call the athletic office at (740) 685-5645.*

*In order for your son or daughter to participate in interscholastic athletics in the Rolling Hills School district, the parent or guardian must designate the type of insurance program that they wish to use in case of injury sustained in a game or practice situation.*

*(PLEASE CHECK THE INSURANCE YOU WILL BE PROVIDING FOR YOUR ATHLETE. THE DATE AND SIGNATURE OF PARENT/GUARDIAN IS ALSO REQUIRED).*

\_\_\_\_ 1. School-time program. Benefits under this plan are limited to expenses not covered by other valid & collectable insurance. Insurance forms are available on the athletic website. By checking this option, Parent and/or Guardian are fully responsible for completion of the form, payment and filing of any claims to the Griffin Insurance Agencies.

\_\_\_\_ 2. Personal responsibility. We do not wish to participate in any type of school insurance. I will assume full responsibility for all expenses incurred as a result of injury to my son or daughter while being a participant in any interscholastic sport in the Rolling Hills Local School District.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**RHLSD PARENT / GUARDIAN AND STUDENTS WHO ARE AT LEAST 18  
YEARS OF AGE CONSENT TO PERFORM URINALYSIS FOR DRUG /  
ALCOHOL TESTING**

*Student Name:* \_\_\_\_\_

*Sport(s):* \_\_\_\_\_

I hereby consent to have my son/ daughter/ ward undergo urinalysis testing for the presence of drugs or alcohol in accordance with the Rolling Hills Local School District Drug and Alcohol Testing policy for Student/ Athletes. I understand that this testing will occur according to the guidelines of the Meadowbrook Drug and Alcohol testing policy for Student/ Athletes. I understand that any urine samples taken for drug/ alcohol testing will be sent only to a certified medical laboratory for actual testing. I hereby give my consent to the medical laboratory selected by the Rolling Hills Local Board of Education, its doctors, employees, or agents together with any clinic, hospital, or laboratory designated by the selected medical laboratory, to perform urinalysis testing on my son/ daughter for the detection of drugs/ alcohol.

I further give my permission to the medical laboratory selected by the Rolling Hills Local Board of Education, its doctors, employees, or agents, to release all results of these tests to the designated School District employees or agents if applicable. I understand that copies of the positive, inconclusive, adulterated or suspect results will also be made available to me.

This consent will be valid for a period of one year from date of execution.

I hereby release, waive, and discharge the Rolling Hills Local Board of Education, its individual members, employees, agents, and anyone acting on its behalf, from any and all liability claims, or causes of action arising from or related to the urinalysis drug/ alcohol testing for Athletic participation and/ or the release of confidential medical information as authorized in this form and in the Drug and Alcohol Testing Policy for Student/ Athletes. By signing this, I am in agreeance that I have the knowledge and a complete understanding of the rules and guidelines included in this policy.

Parent/ Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Date of

Birth: \_\_\_\_\_  
(students over 18)

*List ALL medications and dosage amounts below :*

# Sudden Cardiac Arrest and Lindsay's Law Parent/Athlete Signature Form



**What is Lindsay's Law?** Lindsay's Law is about Sudden Cardiac Arrest (SCA) in youth athletes. It covers all athletes 19 years or younger who practice for or compete in athletic activities. Activities may be organized by a school or youth sports organization.

**Which youth athletic activities are included in Lindsay's law?**

- Athletics at all schools in Ohio (public and non-public)
- Any athletic contest or competition sponsored by or associated with a school
- All interscholastic athletics, including all practices, interschool practices and scrimmages
- All youth sports organizations
- All cheerleading and club sports, including noncompetitive cheerleading

**What is SCA?** SCA is when the heart stops beating suddenly and unexpectedly. This cuts off blood flow to the brain and other vital organs. People with SCA will die if not treated immediately. SCA can be caused by 1) a structural issue with the heart, OR 2) an heart electrical problem which controls the heartbeat, OR 3) a situation such as a person who is hit in the chest or a gets a heart infection.

**What is a warning sign for SCA?** If a family member died suddenly before age 50, or a family member has cardiomyopathy, long QT syndrome, Marfan syndrome or other rhythm problems of the heart.

**What symptoms are a warning sign of SCA?** A young athlete may have these things with exercise:

- Chest pain/discomfort
- Unexplained fainting/near fainting or dizziness
- Unexplained tiredness, shortness of breath or difficulty breathing
- Unusually fast or racing heart beats

**What happens if an athlete experiences syncope or fainting before, during or after a practice, scrimmage, or competitive play?** The coach **MUST** remove the youth athlete from activity immediately. The youth athlete **MUST** be seen and cleared by a health care provider before returning to activity. This written clearance must be shared with a school or sports official.

**What happens if an athlete experiences any other warning signs of SCA?** The youth athlete should be seen by a health care professional.

**Who can evaluate and clear youth athletes?** A physician (MD or DO), a certified nurse practitioner, a clinical nurse specialist, certified nurse midwife. For school athletes, a physician's assistant or licensed athletic trainer may also clear a student. That person may refer the youth to another health care provider for further evaluation.

**What is needed for the youth athlete to return to the activity?** There must be clearance from the health care provider in writing. This must be given to the coach and school or sports official before return to activity.

All youth athletes and their parents/guardians must review information about Sudden Cardiac Arrest, then sign and return this form.

-----  
Parent/Guardian Signature

-----  
Student Signature

-----  
Parent/Guardian Name (Print)

-----  
Student Name (Print)

-----  
Date

-----  
Date

# Ohio Department of Health Concussion Information Sheet

## *For Interscholastic Athletics*

I have read the Ohio Department of Health's Concussion Information Sheet and understand that I have a responsibility to report my/my child's symptoms to coaches, administrators and health care provider.

I also understand that I/my child must have no symptoms before return to play can occur.

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Athlete

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Date



Rev. 01.13

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Athlete

*Please print name*

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Parent/Guardian

*Signature*

---

Date

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Parent/Guardian

*Please print name*



The following procedure should be followed to help promote a resolution to the issue.

- Contact the Coach to set-up an appointment. (See List of school numbers)
- If the Coach cannot be reached after a reasonable period of time, Call the Athletic Director, and an appointment with the Coach will be made.

**IMPORTANT:** Please DO NOT attempt to **CONFRONT** a Coach before or after a contest or practice session. These can be *emotional times* for both the Parent and the Coach.

Meetings of this nature do not promote resolution. In fact they often escalate the issue. This is not good for the Athlete, the Parent, the Coach, and Our School.

#### THE NEXT STEP

What can a parent do if the meeting with the Coach does not provide satisfactory resolution?

Although total agreement may not always be reached, most often, such a meeting does afford the opportunity for productive discussion and better understandings. If a parent desires further communication, please call the Athletic Director to discuss the situation. The appropriate next step will be determined.

#### CHAIN OF COMMAND

The Rolling Hills Local School District in conjunction with its Department of Athletics follows the chain of command listed below. We ask that you observe the order of this line of communication, if you pursue any concern you have with the Athletic Department.

7. Assistant Coach
8. Head Coach
9. Athletic Director
10. Building Principal
11. Superintendent
12. Board of Education

We hope that the information in this “*Communication Guide*” will help you and your child have a rewarding and enjoyable athletic experience.

#### IMPORTANT PHONE NUMBERS

Coach -  
Phone # -  
Athletic Director – 740-685-5645  
Meadowbrook High School – 740-685-2566  
Meadowbrook Middle School – 740-685-2561  
RHLS D Superintendent – Ryan Caldwell – 740-432-6952

T.E.A.M.

(Together Everyone Accomplished More)

Student Signature: \_\_\_\_\_

Parent Signature: \_\_\_\_\_

# Rolling Hills Local School District **ATHLETIC** Communication Guide

Presented by: MHS Department of Athletics