

## HCA Parent/ Chaperone Volunteer Driver Form 2017-2018



***\*only necessary if you plan to be using your vehicle for student transportation***

For the concern and safety of all students, families and staff, please read and sign the following volunteer form before agreeing to be a Parent Driver and / or Chaperone for any HCA event or field trip.

If I am driving my own vehicle I will:

\_\_\_\_ I've attached a copy of my proof of current vehicle insurance and driver's license where it will be kept on file until either document expires.

\_\_\_\_ I will take only as many children in my vehicle as I have fully operating seatbelts.

**As a volunteer driver / chaperone I will:**

- Not make any unplanned stops while driving to or from the field trip or event destination, nor deviate from the planned itinerary.
- Stay with the group of drivers to ensure safety to the larger group.
- If applicable: I will share my cell phone number with other drivers for the purpose of communication due to an emergency.
- I will chaperone the students assigned to me by the classroom teacher or sponsoring teacher as directed per event or field trip.
- I will not text or unnecessarily use my cell phone while driving.

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

(Please Print Full Name)

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

## STUDENT ACADEMIC ELIGIBILITY

To be eligible a student must:

- Be a full time student (6 classes or more)
- Not have one “F” or two “D’s” at eligibility checks

Remaining eligible:

Heritage will conduct weekly grade checks (done every Wednesday) beginning the third week of the first, second, third, and fourth quarters. If an athlete is ineligible on a Wednesday, then he/she is ineligible until the following Wednesday. They may attend practice, but may not play in games. If a student has one “F” or two “D’s” at the end of the first semester, he/she is ineligible for the first two weeks of the second semester.

\*If students become ineligible three times during any one season, the student may no longer be able to participate and will lose the opportunity to letter.

NON HCA students who are homeschooled or have classes at FRCC are expected to provide grades on a weekly basis when requested from the HCA Athletic Secretary.

## ATTENDANCE AND PLAYING TIME GUIDELINES

- Students absent from any class period the day of the game will not be allowed to start (medical and dental appointments excepted). If the student misses more than 2 class periods, he will not be allowed to practice or play.
- Students are expected to be in school on time the morning following a game or may lose playing time at the next game.
- Coaches, in conjunction with the Athletic Director and principal, reserve the right to suspend a player from a practice and/or games(s) for any misconduct or behavior unbecoming to a Christian or to the team.

## FACILITIES, UNIFORMS AND TRANSPORTATION

The Lord has blessed us with equipment, shuttles, uniforms, and the use of facilities and playing fields. Everyone is expected to be a good steward with what we are allowed to use.

- Always leave the field and courts cleaner than the way you found them.
- Keep the school vehicles clean and neat. Please pick up after yourself.
- It is the student’s responsibility to keep their issued uniform washed, cleaned and in good shape.
- Uniforms must be turned in on time or be **assessed a late fee**.
- Lost or damaged uniforms must be paid for by the player.
- Report cards, final transcripts, and graduation cap and gowns will not be released until all items are returned or paid for.
- Players are responsible for shoes, socks, knee pads, shin-guards, etc.
- The coaches will specify what is to be worn for practices.
- Athletes must ride to away games in school vehicles or school-arranged car pools unless otherwise specified by the coach.
- Athletes may ride home with their parents, but not with other students unless given permission from a parent/guardian.
- Athletes that ride home with their parents following a game must notify the coach they are riding in another vehicle.
- Players and parents are responsible for transportation to and from practices and home games.

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

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

# **PARENT PERMIT FOR ATHLETIC PARTICIPATION IN MIDDLE SCHOOL SPORTS**

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## **PARENT OR GUARDIAN PERMIT**

WARNING: Although participation in supervised interscholastic athletics and activities may be one of the least hazardous in which any student will engage in or out of school, **BY ITS NATURE, PARTICIPATION IN INTERSCHOLASTIC ATHLETICS INCLUDES A RISK OF INJURY WHICH MAY RANGE IN SEVERITY FROM MINOR TO LONG-TERM CATASTROPHIC INJURY.** Although serious injuries are not common in supervised school athletic programs, it is impossible to eliminate this risk.

**PLAYERS MUST OBEY ALL SAFETY RULES, REPORT ALL PHYSICAL PROBLEMS TO THEIR COACHES, FOLLOW A PROPER CONDITIONING PROGRAM, AND INSPECT THEIR OWN EQUIPMENT DAILY.**

By signing this Permission Form, we acknowledge that we have read and understood this warning. **PARENTS OR STUDENTS WHO DO NOT WISH TO ACCEPT THE RISKS DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS PERMISSION FORM. By signing this form it allows my students medical information to be shared with appropriate medical staff when necessary in compliance with HIPPA (Health Insurance Portability and Accountability Act) Regulations.**

I hereby give my consent for \_\_\_\_\_ to compete in athletics for Heritage Christian Academy

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

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

**NOTE:** It is strongly recommended by the Colorado Department of Health that individuals participating in athletic events have current tetanus boosters. Tetanus boosters are recommended every 10 years throughout life. Boosters are recommended at the time of injury if more than five years have elapsed since the last booster.

If significant intervening illnesses and/or injuries have occurred, a more complete physical examination should be conducted. The physical examination form must be signed by a practicing physician, physician assistant, or nurse practitioner.

If a student athlete has been injured in practice and/or competition, the nature of which required medical attention, the student athlete should not be permitted to return to practice and/or competition until he/she has received a release from a practicing physician.

**PART II -- MEDICAL HISTORY**

This form must be completed and signed, prior to the physical examination, for review by examining physician. Explain "Yes" answers below with number of the question. Circle questions you don't know the answers to.

MEDICAL HISTORY OF STUDENT & FAMILY		YES	NO	MEDICAL HISTORY OF STUDENT & FAMILY		YES	NO
1.	Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	32.	Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Do you have an ongoing medical condition (like diabetes or asthma)?	<input type="checkbox"/>	<input type="checkbox"/>	33.	Have you ever had herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Are you currently taking any prescription or non prescription (over the counter) medicines or pills?	<input type="checkbox"/>	<input type="checkbox"/>	34.	Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Do you have allergies to medicines, pollens, foods or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	35.	Date of last head injury or concussion:		
5.	Do you have prescriptions for use of epinephrine, adrenalin, inhaler, or other allergy medications?	<input type="checkbox"/>	<input type="checkbox"/>	36.	Have you ever been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Have you ever passed out or nearly passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	37.	Have you ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Have you ever passed out or nearly passed out at any other time?	<input type="checkbox"/>	<input type="checkbox"/>	38.	Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Have you ever had discomfort, pain, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	39.	Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Have you ever had to stop running after ¼ to ½ mile for chest pain or shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>	40.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
10.	Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	41.	Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
11.	Has a doctor ever told you that you have (check all that apply): <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection			42.	When exercising in heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>
12.	Has a doctor ever ordered a test for your heart?	<input type="checkbox"/>	<input type="checkbox"/>	43.	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
13.	Has anyone in your family died suddenly for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	44.	Have you had any other blood disorders or anemia?	<input type="checkbox"/>	<input type="checkbox"/>
14.	Does anyone in your family have a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	45.	Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
15.	Has any family member or relative died of heart problems or sudden death before age 50? (This does not include accidental death.)	<input type="checkbox"/>	<input type="checkbox"/>	46.	Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
16.	Does anyone in your family have Marfan syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	47.	Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
17.	Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	48.	Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
18.	Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	49.	Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
19.	Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or game?	<input type="checkbox"/>	<input type="checkbox"/>	50.	Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
20.	Have you had any broken or fractured bones or dislocated joints?	<input type="checkbox"/>	<input type="checkbox"/>	51.	Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
21.	Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches?	<input type="checkbox"/>	<input type="checkbox"/>	52.	Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
22.	Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	53.	What is the date of your last Tetanus immunization? Date: _____		
				<b>FEMALES ONLY</b>			
23.	Have you ever had an x-ray of your neck for atlanto-axial instability? OR Have you ever been told that you have that disorder or any neck/spine problem?	<input type="checkbox"/>	<input type="checkbox"/>	54.	Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
24.	Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>	55.	Age when you had your first menstrual period?		
25.	Have you ever been diagnosed with asthma or other allergic disorders?	<input type="checkbox"/>	<input type="checkbox"/>	56.	How many periods have you had in the last 12 months?		
26.	Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	57.	Do you take a calcium supplement?	<input type="checkbox"/>	<input type="checkbox"/>
27.	Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Explain "Yes" answers here:</b>			
28.	Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>				
29.	Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>				
30.	Have you had infectious mononucleosis (mono) within the last three months?	<input type="checkbox"/>	<input type="checkbox"/>				
31.	Have you ever had mono or any illness lasting more than two weeks?	<input type="checkbox"/>	<input type="checkbox"/>				

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

Athlete's Signature: \_\_\_\_\_

**PART III -- PHYSICAL EXAMINATION**

NAME: \_\_\_\_\_ SCHOOL: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ SEX: \_\_\_\_\_ AGE: \_\_\_\_\_ DOB: \_\_\_\_\_

\*Tanner Stage or Maturation Index? (males only): \_\_\_\_\_ BP: \_\_\_\_\_

\*Percent Body Fat: \_\_\_\_\_ Pulse: \*(rest) \_\_\_\_\_

\*Audiogram \_\_\_\_\_ \*(Exercise) \_\_\_\_\_

\* Vision: Corrected: (L) \_\_\_\_\_ (R) \_\_\_\_\_ (Both) \_\_\_\_\_ \*(Recovery) \_\_\_\_\_

Uncorrected (L) \_\_\_\_\_ (R) \_\_\_\_\_ (Both) \_\_\_\_\_ \*FEV or Peak Flow (rest) \_\_\_\_\_

\*(Exercise) \_\_\_\_\_ \*(Recovery) \_\_\_\_\_

	N	Abnormal		N	Abnormal
Eyes			Cervical Spine/neck		
Ears			Back		
Nose			Shoulders		
Throat			Arm/elbow/wrist/hand		
Teeth			Knees/hips		
Skin			Ankle/feet		
Lymphatic			Marfan Screen		
Lungs			*Urine		
Heart			*Hemoglobin or HCT and or Iron stores		
Peripheral pulses			^Echocardiogram		
Abdomen			^Neuropsych Testing		
Genitalia/hernia (male only)			^Pelvic Examination		

**\*WHEN MEDICALLY INDICATED**

(Physician judgment based on history, exam, and knowledge of other recent physical and laboratory evaluations)

**^WITH SPECIAL INDICATIONS**

(These studies may be recommended to the athlete because of history or physical findings and may or may not be required before making participation decision.)

**I have reviewed the data above, reviewed his/her medical history form and make the following recommendations for his/her participation in athletics.**

**CLEARED WITHOUT RESTRICTIONS**

Cleared **AFTER** further evaluation or treatment for: \_\_\_\_\_

Cleared for **Limited participation** (check and explain "reason" for all that apply): \_\_\_\_\_

Not cleared for (specific sports): \_\_\_\_\_

Cleared only for (specific sports): \_\_\_\_\_

Reason(s): \_\_\_\_\_

**NOT CLEARED FOR PARTICIPATION:**

Reason(s): \_\_\_\_\_

Other Recommendations: \_\_\_\_\_

Recommend monitoring during early conditioning because of weight/fitness/other  Recommend

restrictions or monitoring of weight loss or gain

Other: Reasons: \_\_\_\_\_

**MD/DO, PA, NP, DE-SPC#, Signature:** \_\_\_\_\_

Date of Examination: \_\_\_\_\_ Date Signed: \_\_\_\_\_

**NAME OF PHYSICIAN/PA/NURSE PRACTITIONER/CERTIFIED-REGISTERED CHIROPRACTOR and degree: (print):**

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_