



AFTER SCHOOL SPORTS PARTICIPATION PACKET

Date: _____

Dear Parents of Student Athlete of _____ School:

Welcome to a new year of school athletics!

In order for your student athlete to participate in tryouts or an afterschool team sport, you must read and sign the documents included in this Afterschool Sports Participation Packet. We will keep these forms on file for the 2022-23 school year.

Please read and complete the following documents included in this Afterschool Sports Participation Packet:

1. Student athlete information
2. Assumption of risk for participation in afterschool sports
3. Assumption of risk for participation in Cheer/Mascot Program
4. Afterschool sports permission
5. Health history and physical examination (to be completed by physician)*
6. Authorization/Consent for Disclosure of Protected Health Information
7. Athletic Insurance Certification
8. Concussion information sheet/INFORMATION
9. Sudden Cardiac Arrest information sheet
10. Student-Athlete Responsibilities
11. Positive Coaching Alliance Pledge for the Athlete and Parent
12. Student grades overview
13. List of community based health clinics

Note: Authorization for Emergency Medical Treatment form is on file with the school office.

Sincerely,

_____, Athletic Director

CC: Principal, _____ School

* Please note, in the interest of student safety, student athletes require clearance from a doctor before participating in our afterschool sports. Information for families in need of medical and/or accident insurance is available in this packet.



Middle School
School Year 2022-23

STUDENT ATHLETE INFORMATION ** Please print clearly **

Student First Name _____ Student Last Name _____

Grade: 6 7 8 Date of Birth: ____/____/____ Home Phone: _____

Home Address: Street _____ Apt _____

City _____ ZIP code _____ Blood Type (if known) _____

Which sport(s) does the student want to participate in?

- | | |
|-------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Boys Basketball | <input type="checkbox"/> Girls Field Hockey |
| <input type="checkbox"/> Boys Soccer | <input type="checkbox"/> Girls Soccer |
| <input type="checkbox"/> Boys Volleyball | <input type="checkbox"/> Girls Volleyball |
| <input type="checkbox"/> Cheerleading | <input type="checkbox"/> Track and Field |
| <input type="checkbox"/> Cross Country | <input type="checkbox"/> Wrestling |
| <input type="checkbox"/> Girls Basketball | <input type="checkbox"/> Other: _____ |

Student health/behavior needs about which the coach should be aware? _____

PARENT/GUARDIAN CONTACT INFORMATION ** Please print clearly **

Mother/Guardian Name _____ Daytime Phone _____

Email _____ Evening Phone _____

Father/Guardian Name _____ Daytime Phone _____

Email _____ Evening Phone _____

Authorized Emergency Contact Name _____ Relationship _____

Email _____ Phone _____

Family Physician Name / Address _____ Phone _____

Health Insurance Carrier (e.g. Blue Cross, Kaiser) _____ Policy Number _____ Phone _____



Middle School
School Year: 2022-23

**CAMPBELL UNION SCHOOL DISTRICT (CUSD)
WAIVER, RELEASE AND INDEMNITY AGREEMENT
ASSUMPTION OF RISK FOR PARTICIPATION IN AFTER SCHOOL SPORTS**

Participant Name: _____

Name of Sport(s): _____

Date(s) of Participation: 2022-2023 school year

THIS FORM IS AN IMPORTANT LEGAL DOCUMENT. IN CONSIDERATION OF MY VOLUNTARY PARTICIPATION IN THE ABOVE AFTER SCHOOL SPORT, I CONFIRM THAT I HAVE CAREFULLY READ THIS FORM THAT EXPLAINS THE RISKS I AM ASSUMING BY PARTICIPATING IN AFTER SCHOOL SPORTS. I UNDERSTAND THAT IF I WISH TO DISCUSS ANY OF THE TERMS CONTAINED IN THIS AGREEMENT, I MAY CONTACT THE DISTRICT OFFICE OF RISK MANAGEMENT AT 408-364-4200 EXT. 6213.

(1) **Assumption of Risks:** I understand that the above-listed after school sport, by its very nature, includes certain inherent risks that cannot be eliminated regardless of the care taken to avoid injuries. The specific risks vary, but may involve minor injury, major injury, and serious injury, including permanent disability and death, and severe social and economic losses which might result not only from my own actions, inactions, or negligence, but the actions, inactions, or negligence of others, the rules of play, or the condition of the premises or of any equipment used. I understand and appreciate the risks that are inherent in the afterschool sport. I hereby assert and agree, on behalf of myself, my family, heirs, personal representative(s), and/or assigns, that my participation in the afterschool sport is voluntary and that I knowingly assume all such risks. I recognize the importance of following instructions regarding proper technique, training and other established safety rules, guidelines and regulations, but understand that I am ultimately responsible for my own safety, and I agree to abide by all rules and regulations governing the afterschool sport.

(2) **Hold Harmless, Indemnity and Release:** In consideration of permission to participate in the above listed after school sport, I agree here and forever, to the maximum extent permitted by law, for myself, my family, my heirs, personal representative(s), and/or assigns, to defend, hold harmless, indemnify and release, the Campbell Union School District ("District"), its Board members, administrators, officers, agents, volunteers and employees, from and against any and all claims, demands, actions, or causes of action of any sort, present or future, on account of damage to personal property, or personal injury, or illness, or death which may result from my participation in the after school sport. This release specifically includes claims based on the negligence of the District and its Board members, administrators, officers, agents, volunteers and employees. I understand that by agreeing to this clause I am releasing claims and giving up substantial rights, including my right to sue, and am doing so voluntarily. No representations, statements, or inducements, oral or written, apart from the foregoing written statement, have been made.

I ACKNOWLEDGE THAT I HAVE READ THE FOREGOING PARAGRAPHS, HAVE BEEN FULLY AND COMPLETELY ADVISED OF THE POTENTIAL DANGERS INCIDENTAL TO ENGAGING IN AFTER SCHOOL SPORTS, AND AM FULLY AWARE OF THE LEGAL CONSEQUENCES OF SIGNING THIS PERMISSION, ASSUMPTION OF RISK, AND HOLD HARMLESS, INDEMNITY AND RELEASE.

Parent/Guardian Name (Print)

Parent/Guardian Signature

Date



UNION SCHOOL DISTRICT

Middle School
School Year: 2022-23

**VOLUNTARY ACTIVITIES PARTICIPATION –ACKNOWLEDGMENT AND ASSUMPTION OF POTENTIAL RISK
CHEER/MASCOT PROGRAM**

I authorize my son/daughter, _____ to participate in the District-sponsored Cheer/Mascot 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 |

I understand and acknowledge that participation in these activities is completely voluntary and as such is not required by District.

Recommendations that may help prevent cheerleading injuries:

- Cheerleaders should have a medical examination before they are allowed to participate including a complete medical history.
- Cheerleaders should be trained by a qualified coach with training in gymnastics and partner stunting. This person should also be trained in the proper methods for spotting and other safety factors.
- Cheerleaders should be exposed to proper conditioning programs and trained in proper spotting techniques.
- Cheerleaders should receive proper training before attempting gymnastic type stunts and should not attempt stunts they are not capable of completing. A qualification system demonstrating mastery of stunts is recommended.
- Coaches should supervise all practice sessions in a safe facility.
- Mini-trampolines and flips or falls off of pyramids and shoulders should be prohibited.
- Pyramids over two high should not be performed. Two high pyramids should not be performed without mats and other safety precautions.
- If it is not possible to have a physician or athletic trainer at games and practice sessions, emergency procedures must be provided. The emergency procedure should be in writing and available to staff and athletes.
- There should be continued research concerning safety in cheerleading.
- When a cheerleader has experienced or shown signs of head trauma (loss of consciousness, visual disturbances, headache, inability to walk correctly, disorientation, or memory loss) she/he should receive immediate medical attention and should not be allowed to practice or cheer without permission from the proper medical authorities. It is important for a physician to observe athletes with head injuries for several days following the injury.
- Cheerleading coaches should have a safety certification. The American Association of Cheerleading Coaches and Advisors offers this certification. Refer to <http://www.AACCA.org> .

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 that may be associated with participation in such activities. I further understand and acknowledge that my son/daughter must be covered by private medical insurance and/or student accident insurance to participate in this activity.

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

I understand and agree that any and all school and District rules apply during any and all events associated with preparing for and/or participating in this activity.

I acknowledge that I have carefully read this VOLUNTARY ACTIVITIES PARTICIPATION FORM, and that I understand and agree to its terms.

Parent/Guardian name (print)

Parent/Guardian Signature

Date

This form must be completed, signed and on file at the school prior to participation in the CHEER/MASCOT activity.



_____ Middle School School Year: 2022-23

**CAMPBELL UNION SCHOOL DISTRICT (CUSD)
AFTER SCHOOL SPORTS PERMISSION**

Participant Name: _____ Name of School: _____

Name of Sport(s): _____ Date(s) of Participation: 2022-2023 school year

By my signature below, I hereby:

- Acknowledge that transportation is the parent/guardian responsibility, and
- Give permission for my son/daughter to participate in the above-described after school sport.

I realize that this activity is voluntary as part of the CAMPBELL UNION SCHOOL DISTRICT ("District") program. I am aware of the transportation arrangements for this activity and acknowledge that if the school is providing no transportation, I have complete and sole responsibility for all transportation arrangements for my student athlete. I am aware that the District does not provide coverage for medical treatment in connection with this activity. If a participant does not have private medical insurance, low-cost school insurance is available through the District. I further acknowledge that the District does not automatically provide for medical coverage for participants in this activity.

I also understand and acknowledge that, in order to participate in the above-described afterschool sport, I need to provide the separately dated and signed Waiver, Release and Indemnity Agreement and Assumption of Risk for Participation in Voluntary After School Sports and Medical Treatment Authorization forms included in this packet to the District in before participating the afterschool sport.

Parent/Guardian Name (Print)

Parent/Guardian Signature

Date



Middle School
School Year: 2022-23

HEALTH HISTORY AND PHYSICAL EXAMINATION

The school district will keep and maintain this as confidential information.

Student Name: First, Last _____ Birthdate ____/____/____ Male ___ Female ___

REASON FOR REFERRAL: ___ATHLETICS ___FOR THE FOLLOWING CONCERNS: _____

PARENT/GUARDIAN AUTHORIZATION: For release of health information, I hereby give my consent to the school named above to receive from, or send to the following health care professional(s), Dr. _____, any health information concerning my child.

Parent/Guardian Name (Print) _____ Parent/Guardian Signature _____ Date _____

STUDENT HEALTH HISTORY – TO BE COMPLETED BY PARENT OR GUARDIAN

Currently under the care of:

Doctor's Name: _____ For what condition? _____

Dentist's Name: _____

Medication: Please indicate the name and dosage of any medication(s) that your child is taking. _____

CHECK YES FOR ANY CONDITIONS THAT APPLY and CHECK YES OR NO FOR EACH CONDITION

Yes	No	Condition	Yes	No	Condition
<input type="checkbox"/>	<input type="checkbox"/>	Asthma, Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Dental Problem	<input type="checkbox"/>	<input type="checkbox"/>	Down Syndrome
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problem	<input type="checkbox"/>	<input type="checkbox"/>	If yes to Down Syndrome, have cervical spine (neck bone) x-rays been done?
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis (Tb)	<input type="checkbox"/>	<input type="checkbox"/>	If yes to Down Syndrome, Atlanto Axial Instability?
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Special Diet _____
<input type="checkbox"/>	<input type="checkbox"/>	Speech impairment	<input type="checkbox"/>	<input type="checkbox"/>	Exercise induced wheezing
<input type="checkbox"/>	<input type="checkbox"/>	Colon Problem	<input type="checkbox"/>	<input type="checkbox"/>	Tendency to bleed easily
<input type="checkbox"/>	<input type="checkbox"/>	Stomach Problem	<input type="checkbox"/>	<input type="checkbox"/>	Parent/Sibling (under 40) died of heart disease
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease/Heart Defect/High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Emotional/psychiatric/behavioral problems
<input type="checkbox"/>	<input type="checkbox"/>	Allergy to the following (be specific)	<input type="checkbox"/>	<input type="checkbox"/>	Absence of one kidney or testicle
		Medicine _____	<input type="checkbox"/>	<input type="checkbox"/>	Serious bone or joint disorder
		Foods _____	<input type="checkbox"/>	<input type="checkbox"/>	Concussion or serious head injury
		Insect Sting/Bite _____	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell trait or disease
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain or Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Major surgery or serious illness
<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Dentures/false teeth
<input type="checkbox"/>	<input type="checkbox"/>	Hearing aid/hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	Impaired motor ability
<input type="checkbox"/>	<input type="checkbox"/>	Heat stroke/exhaustion	<input type="checkbox"/>	<input type="checkbox"/>	Uses a wheelchair
<input type="checkbox"/>	<input type="checkbox"/>	Contact lenses/eyeglasses	<input type="checkbox"/>	<input type="checkbox"/>	Other problem that would interfere with sports participation _____

Further explanation of above: _____



UNION SCHOOL DISTRICT

 Middle School
 School Year: 2022-23

HEALTH HISTORY AND PHYSICAL EXAMINATION FORM (Continued)

Student's Name: _____

_____/_____/_____
 Birthdate

SPECIAL NEEDS – ONE CHECK AND PARENT/GUARDIAN INITIALS FOR EACH LINE IS REQUIRED:

YES	NO	Initials	Health or Special Need
			Participant has no special health needs the staff should be aware of, and no medication is required
			Participant has a chronic allergic condition or temporary medical or physical condition, and instructions are attached. No. of attached pages: _____.
			Participant has a special need covered by Section 504 and/or an individualized education plan (IEP)
			Participant has a history of head injury or concussion. If yes, attach description with a copy of written clearance form from your licensed healthcare provider. No. of attached pages: _____.
			Other (please describe): No. of attached pages: _____.



Middle School
School Year: 2022-23

UNION SCHOOL DISTRICT

CAMPBELL UNION SCHOOL DISTRICT

Student Authorization/Consent for Disclosure of Protected Health Information

I/we, _____ (Name(s) of Parent(s)/Guardian(s)),

parent(s)/guardian(s) of, _____ (Name of Student) hereby authorize _____ and

its administrators, athletic trainers and health care personnel to disclose my protected health information including, without limitation, any information regarding any injury, illness, treatment or participation related to or affecting my training for and participation in athletics to the District, and its designated employees, agents and/or contractors. I/we further authorize the District to disclose, and/or use, such information as provided herein.

I/we understand that my student's participation and protected health information, including, without limitation, conditions, injuries, or illnesses resulting from or affecting training for or participation in athletics, may be disclosed to, and/or used by, the District, and any third party expressly authorized by the District to receive such information for the purposes described in this paragraph. The information provides the District, athletic leagues using District facilities, and individual schools, with injury, relevant conditions and illnesses, and participation data that identify individual students' fitness to participate in (a) specific athletic program(s) and, if applicable, any special conditions related to such participation.

I/we understand that this protected health information is protected by federal regulations under either the Health Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) and may not be disclosed without either my authorization under HIPAA or my consent under the Buckley Amendment. I/we understand that my signing of this authorization/consent is voluntary and that my institution will not condition or withhold any health care treatment or payment, enrollment in a health plan or receipt of any benefits (if applicable) on whether I/we provide the consent or authorization requested for this disclosure. I/we also understand that I/we am/are not required to sign this authorization/consent in order for my/our child to be eligible for participation in District athletics.

I/we understand that while HIPAA regulations may not apply to District use or disclosure of my/our child's injury/illness information, the District is committed to protecting his/her privacy.

This authorization/consent for transfer of protected health information expires at the end of the school year following from the date of my signature below, but I/we have the right to revoke it in writing at any time by sending written notification to the District. I/we understand that a revocation takes effect on its request date and does not affect any action taken prior to that date.

The undersigned hereby acknowledges that I/we knowingly and voluntarily assume(s) all risks to his/her child/ward or we/him/herself, as stated, and expressly acknowledges my/our intention, by executing this instrument, to exempt and relieve the District, its officers, agents, volunteers and employees, from any liability for personal injury, bodily injury, property damage or wrongful death that may arise out of or in any way be connected with this consent. I/we have read and understand the foregoing and have voluntarily signed this consent. I/we am/are aware of the potential risks involved in this consent and I/we am/are fully aware of the legal consequences of signing this instrument.

Printed Name of Student

Parent/Guardian Name(s) (Please Print)

Parent/Guardian Signature(s)

Date

Phone Number(s)

Street Address

City

Zip Code



UNION SCHOOL DISTRICT

**CAMPBELL UNION SCHOOL DISTRICT (CUSD)
ATHLETIC INSURANCE CERTIFICATION FORM**

Middle School
School Year: 2022-23

Student's Name: _____

_____/_____/_____
Birthdate

I hereby certify, under penalty of perjury, that the above-named pupil is covered by valid insurance that provides the following:

(1) Insurance protection for medical and hospital expenses resulting from accidental bodily injuries in one of the following amounts: (Ed. Code 32221)

- (a) A group or individual medical plan with accidental benefits of at least two hundred dollars (\$200) for each occurrence and major medical coverage of at least ten thousand dollars (\$10,000), with no more than one hundred dollars (\$100) deductible and no less than eighty percent (80%) payable for each occurrence.
- (b) Group or individual medical plans which are certified by the Insurance Commissioner to be equivalent to the required coverage of at least one thousand five hundred dollars (\$1,500).
- (c) At least one thousand five hundred dollars (\$1,500) for all medical and hospital expenses.

(2) I hereby agree that this policy shall not be cancelable without at least 10 days prior written notice to the District.

Insurance protection in any of the above amounts shall be provided through group, blanket, or individual policies of accident insurance from authorized insurers or through a benefit and relief association, such as California Interscholastic Protection Fund, for the death or injury to members of athletic teams arising while such members are engaged in or are preparing for an athletic event promoted under the sponsorship or arrangements of the educational institution or a student body organization thereof or while such members are being transported by or under the sponsorship or arrangements of the school districts or a student body organization thereof to or from school or other place of instruction and the place of the athletic event. Minimum medical benefits under any insurance required by this paragraph shall be equivalent to the three dollars and fifty cents (\$3.50) conversion factor as applied to the unit values contained in the minimum fee schedule adopted by the Department of Industrial Relations of the State of California, effective October 1, 1966. (Ref. Ed. Code 32221)

I will maintain the above coverage during the current school year or will immediately notify the school if the coverage terminates or does not meet the above requirements.

Insurance Company

Parent/Guardian Name(s) – Please Print

Policy/Group No.

Parent/Guardian Signature(s)

Policy Expiration Date

Signature Date



UNION SCHOOL DISTRICT

Middle School
School Year: 2022-23

MIDDLE SCHOOL ATHLETICS CONCUSSION INFORMATION AND AGREEMENT

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.

SYMPTOMS MAY INCLUDE ONE OR MORE OF THE FOLLOWING:

- | | |
|----------------------------------|-------------------------------------------------------------|
| Headaches | Amnesia |
| “Pressure in head” | “Don’t feel right” |
| Nausea or vomiting | Fatigue or low energy |
| Neck pain | Sadness |
| Balance problems or dizziness | Nervousness or anxiety |
| Blurred, double, or fuzzy vision | Irritability |
| Sensitivity to light or noise | More emotional |
| Feeling sluggish or slowed down | Confusion |
| Feeling foggy or groggy | Concentration or memory problems
(forgetting game plays) |
| Drowsiness | Repeating the same question/comment |
| Change in sleep patterns | |

SIGNS OBSERVED BY TEAMMATES, PARENTS AND COACHES INCLUDE:

- | | |
|-------------------------------------------|-----------------------------------------------|
| Appears dazed | Slurred speech |
| Vacant facial expression | Shows behavior or personality changes |
| Confused about assignment | Can’t recall events prior to hit |
| Forgets plays | Can’t recall events after hit |
| Is unsure of game, score, or opponent | Seizures or convulsions |
| Moves clumsily or displays incoordination | Any change in typical behavior or personality |
| Answers questions slowly | Loses consciousness |

WHAT CAN HAPPEN IF MY CHILD KEEPS ON PLAYING WITH A CONCUSSION OR RETURNS TO SOON?

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.

(Continued on next page)



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 CIF Bylaw 313 now requires implementation of long and well-established return to play concussion guidelines that have been recommended for several years:

- A student-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 for the remainder of the day.”

and

- A student-athlete who has been removed 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 It is better to miss one game than miss the whole season. When in doubt, the athlete sits out.

For current and up-to-date information on concussions go to: <http://www.cdc.gov/ConcussionInYouthSports/>

I understand that there is an element of risk associated with all athletic competitions and that the district cannot guarantee that students will not be injured, despite a commitment to every participant’s health and welfare.

Student-Athlete Name Printed

Parent or Legal Guardian Printed

Parent or Legal Guardian Signature

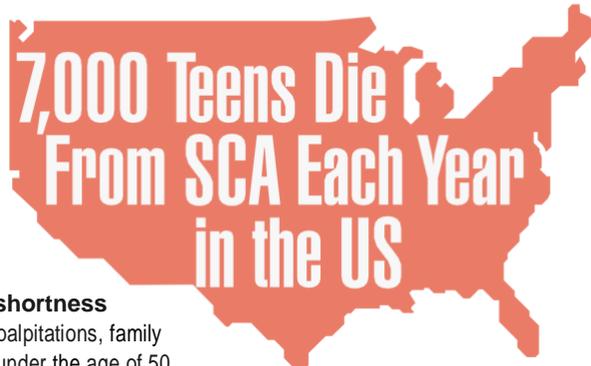
Date

SCREEN YOUR HEART & SAVE A LIFE

Education and action. Saving lives is paramount to our mission and prevention is our goal.

What Is Sudden Cardiac Arrest?

Sudden Cardiac Arrest (SCA) is not a heart attack. It's an abnormality in the heart's electrical system that abruptly stops the heartbeat. It's caused by an undetected congenital or genetic heart condition.



Warning signs include shortness of breath, lightheadedness, chest pain, heart palpitations, family history of SCA or unexplained sudden death under the age of 50.

1 in 100 Youth At Risk

SCA is the #2 killer of youth under 25. These youth would be assessed with a simple EKG, but EKGs are not a part of a well-child or pre-sports exam.



1 Athlete Dies Every 3 Days

SCA is 60% more likely to occur during exercise or sports activity, so athletes are at greater risk. SCA is also the leading cause of death on school campuses.

60% At Risk More Susceptible

Time Critical

If not properly treated within minutes, SCA is fatal in 92% of cases.



An Automated External Defibrillator Can Save Lives



An automated external defibrillator (AED) used within the first five minutes is the only way to restore normal heart activity to an SCA victim. The average arrival time for EMTs is six to 12 minutes. We need more AEDs and training so anyone can react quickly.

What Is An EKG?

An EKG measures your heart rate and electrical activity through electrodes attached via small patches with a mild adhesive to the chest, legs and arms.



Screening Results

Always follow up with your family doctor and add this baseline EKG to your child's medical chart. If the EKG is abnormal, be sure to see your doctor within two weeks for follow-up testing and treatment.

Regular Exams Are Important

An EKG can only detect 60% of heart conditions that put teens at risk, so it's important to have regular exams with your family physician. International recommendations are to repeat the EKG every other year through age 25.

Screenings Are Painless

The EKG reads your heartbeat from electrodes attached to your body. There are no needles or x-ray exposure. It takes just a few minutes and is completely painless.



AVE

EPSaveALife.org



**MIDDLE SCHOOL
STUDENT-ATHLETE RESPONSIBILITIES**

1. Respect other athletes on your team and others (no yelling, cursing, or physical contact)
2. No “horseplay” (pantsing, chasing someone) or suspension will result.
3. Respect equipment, be responsible; or it could cost you money to replace.
4. Permission cards must be signed and turned in before you begin practice.
5. Uniforms must be turned in within 2 days after your last game in clean and good condition, or report cards will be held and a \$50.00 fee will be charged.
6. Praise athletes for effort or accomplishments and keep your criticism to yourself; let the coach correct each player.
7. If riding the bus to and from athletic events:
 - a. Only you not your friends, are allowed on the bus.
 - b. You must behave respectfully and follow bus rules.
 - c. If not riding the bus home, you must only go home with your parent/guardian.
8. If your practice starts after 3:30 p.m., you must leave campus and come back for practice; unless an arrangement has been made with your coach.
9. You must have and maintain a minimum 2.0 (C grade point average) and no Fs in all of your classes. Your grades will be checked.
10. Remember; be a positive role model for your school.
11. While improving at your sport, remember to HAVE FUN!!!!

Violation of the above rules could result in suspension from a game/meet, suspension from the team, and/or suspension from school. Your parent/guardian will be contacted.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

**Positive Coaching Alliance
ATHLETE'S PLEDGE**

Please read, sign, and return to the coach or appropriate official.

1. Making Myself Better

- I understand that officials can make mistakes. If a "bad" call is made against my team, I will Honor the Game and remain silent!
- I will give maximum effort in workouts, practices, and competitions.
- I will have a teachable spirit. I will accept feedback so I can learn and get better.
- I will work hard on my mental game, and I will use a variety of tools such as visualization, positive self-talk, and mistake rituals to allow me to move past failures quickly and refocus on the next play.

2. Making My Teammates Better

- I will look for leadership opportunities to help my team achieve its goals.
- I will be a positive teammate. I will support my teammates by building them up. When I do criticize, I will do it constructively and at the right time in the right way.
- I will be a team player who helps build strong team chemistry. My first priority will be team success, and I will adjust and accept my role to help the team.

3. Making the Game Better

- I will honor the game by respecting the rules, opponents, officials, teammates, and myself.
- I will use my status and influence as an athlete to improve my school community.

Print Athlete's Name

Athlete's Signature

Date

For more from Positive Coaching Alliance, visit www.positivecoach.org

**Positive Coaching Alliance
PARENT'S PLEDGE**

Please read, sign, and return to the coach or appropriate official.

Print Athlete's Name

1. As a Second-Goal Parent I will let players and coaches take responsibility for the first goal of winning. I will relentlessly focus on the second, more important, goal of using sports to teach life lessons to my child and other youth.
2. I will use positive encouragement to fill the Emotional Tanks of my children, their teammates, and coaches. I understand that people do their best with full E-Tanks.
3. I will reinforce the ELM Tree of Mastery with my child (E for Effort, L for Learning, M for bouncing back from mistakes). Because I understand a mastery approach will help my child be successful in sports and in life, I will encourage my child to
 - put in a high level of effort to get better,
 - cultivate a Teachable Spirit to continue to learn and improve,
 - use a Mistake Ritual (e.g., "flushing mistakes") to quickly rebound from mistakes.
4. I will set an example for my child by Honoring the Game and will encourage him/her to remember ROOTS – respect for the Rules, Opponents, Officials, Teammates, and Self. If the official makes a "bad" call against my team, I will Honor the Game and be silent!
5. I will use a self-control routine to avoid losing my composure when things go wrong. I will take a deep breath, turn away from the game to refocus, counts backwards from 100 or use self-talk ("I need to be a role model. I can rise above this.").
6. I will engage in No-Directions Cheering. I will limit my comments during the game to encouraging my child and other players (from both teams).
7. I will get my child to practice and games on time and will be on time picking my child up after games and practices.
8. I will refrain from making negative comments about my child's coach in my child's presence. I understand that this will help to avoid planting negative seeds in my child's head that can negatively influence my child's motivation and overall experience.

Parent/Guardian Name - Print

Parent/Guardian Signature

Date

For more from Positive Coaching Alliance, visit www.positivecoach.org

Physicals for the
2021/2022 school year
are no longer valid

ATHLETIC PHYSICAL EXAMINATION FORM

Campbell Union School District

VALID PHYSICAL FOR 2022/23
MUST BE PERFORMED AFTER
JUNE 10, 2022

Name: _____ DOB: _____

Height: _____ Weight: _____ Pulse: _____ BP _____ / _____

Vision: R 20/ _____ L 20/ _____ Corrected Y N Pupils: Equal _____ Unequal _____

	NORMAL	ABNORMAL FINDINGS	INITIALS
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Hearing			
Lymph Nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			

PHYSICIANS STATEMENT

An annual physical examination certifying that the student is physically fit to participate in athletics is required before a student may try out, practice, or participate in interscholastic athletic competition. I hereby certify that the above named student was examined by me and found physically fit to engage in interscholastic athletics for the current school year. (June 10, 2022 to June 9, 2023)

Date Examined: _____ Physician Name: _____

PLEASE USE STAMP

Physician Signature: _____ Phone: _____

Free & Income-Based Clinics Near Campbell, California

[The following information is provided by FreeClinics.com <https://www.freeclinics.com/cit/ca-campbell>]

Listed below are 10 of the free, income-based health clinics, public health department clinics, community health centers that we have located in the Campbell, CA area. For the most part, these clinics are for low income persons or those without insurance.

Review all of the information we have provided for the clinics. Some of them provide a wide array of services ranging from free to sliding scale services. We have provided as much detailed information including phone numbers, emails, and websites where available.

Clinic services we list include:

- ▶ Dental Clinic Services
 - ▶ Medical Clinic Services
 - ▶ Women's Health Clinic Services
 - ▶ Adult Health Clinic Services
 - ▶ Pediatric Health Clinic Services
 - ▶ Pediatric Dental Clinic Services
 - ▶ Behavioral Health Clinic Services
- and more!

1. **Santa Clara Valley Health and Hospital System - San Jose**
408-885-5700
2. **Valley Specialty Center -San Jose**
408-885-7806
3. **Asian Americans for Community Involvement -San Jose**
(408) 975-2730
The team of multicultural and multilingual professionals at AACI works to bridge cultural gaps through an array of services and programs.
4. **Homeless Mobile Medical Unit - San Jose**
408-885-7049
5. **Valley Health Center - Moorpark - San Jose**
408-885-7049
6. **Bascom Health Center -San Jose**
(408) 885-4600
7. **Westwood Clinic - San Jose**
(408) 445-3400
8. **Indian Health Center of Santa - San Jose**
(408) 445-3400
9. **O'Connor Family Health Center - San Jose**
(408) 283-7676
10. **San Jose County Health Department Park Alameda -San Jose**
(408) 792-5200