SIMON KENTON
HIGH SCHOOL
ATHLETIC DEPARTMENT
11132 Madison Pike Independence, KY 41051

2020-21 Simon Kenton HS Athletic Paperwork

The paperwork included in this packet **MUST** be completed before you can participate in athletics at Simon Kenton HS. Please make sure that all paperwork is signed and completed. The athlete will not be permitted to participate in tryouts, practices, or games until **ALL** paperwork is completed and turned in.

Thank you.

PIONEERS

Kenton County School District | *It's about ALL kids.*

THE KENTON COUNTY BOARD OF EDUCATION
1055 EATON DRIVE, FORT WRIGHT, KENTUCKY 41017
TELEPHONE: (859) 344-8888 / FAX: (859) 344-1531
WEBSITE: www.kenton.kyschools.us
Dr. Henry Webb, Superintendent of Schools

The Kenton County School District
Athletics Pre-Participation Annual Checklist

All students prior to participating in any interscholastic practice or game must complete the checklist below and the student athlete and their parent or legal guardian must sign indicating completion of required forms and acknowledgement that informational materials were received and reviewed.

Board policy requires that students participating on a school sponsored team or in the band must have medical insurance. Students will not allowed to participate in practices, tryouts, or games until proof of insurance is provided to school. Families are encouraged to review their health insurance policy to assure the coverage is adequate. Students without insurance must purchase the insurance plan offered through the school before they will be permitted to participate.

In addition to providing medical insurance, parents/guardians must also assume responsibility for any other expenses that may result from an accident or injury during extracurricular activities. Other expenses may include ambulance fees, medical plan co-payment, or insurance deductible fees. The Kentucky High School Athletic Association (KHSAA) catastrophic insurance plan will continue to cover students in situations where medical expenses exceed $25,000.00

- ☐ Hudl video release form (teams that use Hudl only)
- ☐ Kentucky High School Athletic Association (KHSAA) Athletic Participation/Physical Examination Form Consent and Release Form has been completed and submitted.
- ☐ Voluntary Student Accident Insurance coverage pamphlet received and coverage was:
  - ○ Accepted and submitted to K & K Insurance Company
  - ○ Declined
- ☐ If Voluntary Student Accident Insurance is declined then a copy of insurance has been provided
- ☐ Consent of Liability Form has been completed and submitted
- ☐ Council on Disease Control (CDC) Heads - up concussion fact sheet for athletes was received.
- ☐ Council on Disease Control (CDC) Heads - up concussion fact sheet for parents was received.
- ☐ Copy of insurance card provided (both sides of card copied)
- ☐ Participation fee (check made out to Simon Kenton HS): $40.00

Print Name of Athlete: _____

Sport(s) in which student participates: _____

Athlete's Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

(Return this form to Coach with physical and other required paperwork)

Athletic Participation Form
Parental and Student Consent and Release
For High School Level (grades 9-12) participation

KHSAA Form GE04
High School Parental Permission and Consent
Rev. 7/19, page 1 of 2

*The student and parents/guardian must read this statement carefully and sign where required. By signing this form, all parties agree that they have accurately completed all sections of the form and have read and agree to the terms of this form as detailed. This form **must** be completed before the student participates (hereinafter including try out for, practice and/or compete) in interscholastic athletics. This form should be kept in a secure location until the student has exhausted eligibility, graduated from high school and reached the age of 19.*

ATHLETE INFORMATION *(This part must be completed by the student and family)*

Name (Last, First, Initial) _____ School Year _____

Home Address (Street, City, State, Zip): _____

Gender _____ Grade _____ School _____

Date of Birth: _____ Birth Place (County, State): _____

School Attendance History

Grade	School Name	School Year		Varsity Play – (Yes/No)?
9				
10				
11				
12				

I am planning to participate in the following (check all you might try to play):

☐ Baseball ☐ Basketball ☐ Cross Country ☐ Football ☐ Golf ☐ Soccer
☐ Softball ☐ Swimming ☐ Tennis ☐ Track and Field ☐ Volleyball ☐ Wrestling
☐ Archery ☐ Bass Fishing ☐ Bowling ☐ Competitive Cheer ☐ Dance
☐ Other _____

EMERGENCY CONTACT INFORMATION

_____ _____
Name (please print) Relation to Student

_____
Emergency Contact Address, including City, State and Zip

_____ _____
Daytime Phone Cell Phone

REQUIRED INSURANCE INFORMATION (KHSAA Bylaw 12)

Prior to participation in practice or contests (including trying for a place on a team) in any sport or sport activity during the limitation of seasons as defined in Bylaw 23, all students are required to have medical insurance with coverage limits of at least $25,000. If this coverage is provided through the school, contact the Principal or Athletic Director regarding any potential claim. Individual schools and districts may impose additional requirements for insurance or coverage during additional periods for activities outside of Bylaw 23.

_____ _____ _____ _____
Insurance Carrier Policy Number / ID Number Group Number Plan

EMERGENCY TREATMENT INFORMATION

The following information is recorded solely for potential hospitalization and emergency care needs and is not required to be recorded on this form. However, those failing to provide this information should be aware that this might be required by emergency treatment facilities prior to rendering service, and failure to provide could result in lack of appropriate care.

_____ _____
Social Security Number Birth Date

CONSENT INFORMATION TO PARTICIPATE, ACKNOWLEDGMENT OF RISK, ACKNOWLEDGEMENT OF ELIGIBILITY RULES, LIABILITY WAIVER AND CONSENT AND RELEASE

As parent/legal guardian, I agree to allow my child to participate in interscholastic athletics.

The student and parent/legal guardian recognize that participation in interscholastic athletics involves some inherent risks for potentially severe injuries, including but not limited to death, serious neck, head and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to internal organs, serious injury to bones, joints, ligaments, muscles, tendons, and other aspects of the muscular skeletal system, and

serious injury or impairment to other aspects of the body, or effects to the general health and well being of the child. Because of these inherent risks, the student and parent/legal guardian recognize the importance of the student obeying the coaches' instructions regarding playing techniques, training and other team rules. By signing this form, the student and parent/legal guardian acknowledge that the student's participation is wholly voluntary and to having read and understood this provision.

The student and parent/legal guardian individually and on behalf of the student, hereby irrevocably, and unconditionally release, acquit, and forever discharge the KHSAA and its officers, agents, attorneys, representatives and employees (collectively, the "Releasees") from any and all losses, claims, demands, actions and causes of action, obligations, damages, and costs or expenses of any nature (including attorney's fees) that the student and/or parent/legal guardian incur or sustain to person, property or both, which arise out of, result from, occur during or are otherwise connected with the student's participation in interscholastic athletics if due to the ordinary negligence of the Releasees.

The student and parent/legal guardian acknowledge that they have read and understood the KHSAA Bylaws by distribution under the handbook links at http://khsaa.org/. Please be aware that a student is subject to the one-year period of ineligibility the bylaw commonly referred to as the "Transfer Rule," upon participation in any varsity contest regardless of the amount of participation or lack thereof.

The student and parent/legal guardian agree to abide by the KHSAA Bylaws and Due Process Procedure as now enacted or later amended. The student and parent/legal guardian further acknowledge that they agree to abide by the rulings of the Commissioner, Assistant Commissioner, Hearing Officer and Board of Control.

The student and parent/legal guardian acknowledge that the student must have medical insurance coverage up to a limit of $25,000 in order to be eligible to participate in interscholastic athletics.

The student and parent/legal guardian, individually and on behalf of this student, give the high school, the KHSAA and their representatives permission to release this student's demographic information (including motion picture and still photographic images) and participation statistics (including height, weight and year in school, participation history and other performance based statistics) and other information as may be requested, and agree that the student may be photographed or otherwise digitally or electronically captured during school-based competition. All of this material may be used without permission or compensation specifically related to the KHSAA and its events.

The student and parent/legal guardian consent to this student receiving a physical examination as required by the KHSAA.

The student and parent/legal guardian, individually and on behalf of this student, consent to the high school and the KHSAA and their representatives to use and disclose the necessary personally identifiable information from the student's education records including academic, financial and health care information, to third parties including school representatives, coaches, athletic trainers, medical facilities, medical staffs, KHSAA legal counsel and the media, for the purpose of receiving proper/necessary medical care and complying with the KHSAA bylaws, including making determinations regarding eligibility to participate in interscholastic athletics and any administrative or legal proceedings resulting from participation or attempted participation in interscholastic athletics, without such disclosure constituting a violation of rights under the Family Educational Rights and Privacy Act. The student and parent/legal guardian, individually and on behalf of this student, further release the high school, the KHSAA and their representatives from any and all claims arising out of the use and disclosure of said necessary personally identifiable information, and agree to release to the high school, the KHSAA, and their representatives, upon request, the detailed and completed application for financial aid.

The student and parent/legal guardian, individually and on behalf of the student, hereby acknowledge that they are aware of and will review if desired, the education materials available through the KHSAA, the Centers for Disease Control and other agencies regarding education all individuals with respect to nature and risk of concussion and head injury, including the continuance of play after concussion or head injury.

The student and parent/legal guardian, individually and on behalf of the student, hereby consent to allow the student to receive medical treatment that may be deemed advisable by the high school, the KHSAA, and their representatives in the event of injury, accident or illness while participating in interscholastic athletics, including, but not limited to, transportation of the student to a medical facility.

STUDENT AND PARENT/GUARDIAN ACKNOWLEDGMENT OF RISK, ELIGIBILITY RULES, LIABILITY WAIVER AND CONSENT AND RELEASE AND EMERGENCY PERMISSION FORM

Students' Name (please print) _____ School _____

Student and Parent/Guardian Address including City, State and Zip _____

Signature of Student _____ Date _____

Please list above any health problems/concerns this student may have, including allergies (medications / others) and any medications presently being used _____

Name of Parent(s)/Guardian(s) who has/have custody of this student (please print) _____ Emergency Phone Number _____

Signature of Parent(s)/Guardian(s) who has/have custody of this student _____ Date _____

PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex at birth (F, M): _____

List past and current medical conditions. _____

_____

Have you ever had surgery? If yes, list all past surgical procedures. _____

_____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

_____

_____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

_____

_____

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU *(CONTINUED)*	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease?		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
FEMALES ONLY	**Yes**	**No**
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "Yes" answers here.

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

■ PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN/STATUTORILY AUTHORIZED PROVIDER REMINDERS

1. Consider additional questions on more-sensitive issues.
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart ** • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

** Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

_____

_____

☐ Medically eligible for certain sports

_____

_____

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: _____

_____

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are 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 medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: _____

_____

_____

Medications: _____

_____

_____

Other information: _____

_____

_____

Emergency contacts: _____

_____

_____

PLEASE INCLUDE A COPY OF YOUR HEALTH INSURANCE CARDS: FRONT AND BACK

Hudl Release

STUDENTS 09.14 AP.24

Release/Inspection of Student Records/Medicaid Consent

TO THIRD PARTY

Name of School: _____ Date: _____

The Kenton County School District is hereby authorized to:

× Release or copy ☐ Permit the inspection of

the records listed below for _____, who was born on
Student's Name Please Print

_____. THE INDIVIDUAL OR AGENCY TO WHOM THIS INFORMATION IS TO BE RELEASED IS HUDL. HUDL IS A PRODUCT AND SERVICE OF AGILE SPORTS TECHNOLOGIES, INC.
I understand that the records affected are checked below, along with the reason(s) for the requested release or authorization to inspect.

RECORDS	PURPOSE
☐ All cumulative records	
☐ Attendance record only	
☐ Grade records only	
☐ Standardized test data only	
☐ Special education records only	
× Other: Student Demographic Data: Name, grade, phone number, address, email address, parent/guardian name(s), ACT, GPA	The purpose of the disclosure is to edit and share video, study associated play diagrams, and create quality highlight reels for entertainment and recruiting purposes.

This release is effective only for the specified records or types of records on hand as of the date you sign below UNLESS you specifically authorize further release of the specified records or types of records as follows. (Check and initial ONE of the following.)

☐ I authorize **on-going release** of the specified records or types of records to the entity/individual specified until student reaches age of 18 unless earlier revoked in writing. (Initials _____)

× I authorize release of the specified records or types of records until the end of the present school year (June 30th) unless earlier revoked in writing. (Initials _____)

_____ _____
Signature of Parent/Guardian or Individual Acting as Parent under FERPA* ***Date***

_____ _____
Signature of Student, 18 or Older or Attending Post-secondary Institution ***Date***

*Living in the student's home in the absence of the parent on a day-to-day basis

MEDICAID CONSENT

☐ I have received my Annual Notification of Parent Rights regarding Medicaid billing, and I understand and agree that the District may access my child's or my public benefits or insurance to pay for services under the Individuals with Disabilities Education Act. (This also authorizes release of education records as specified above.)

_____ _____
Signature of Parent/Guardian ***Date***

Review/Revised:7/7/14

Return if team uses Hudl.

Kenton County School District | *It's about ALL kids.*

THE KENTON COUNTY BOARD OF EDUCATION
1055 EATON DRIVE, FORT WRIGHT, KENTUCKY 41017
TELEPHONE: (859) 344-8888 / FAX: (859) 344-1531
WEBSITE: www.kenton.kyschools.us
***Dr. Henry Webb*, Superintendent of Schools**

Dear Parent or Guardian,

Any medication, prescription or non-prescription, which a student requires during school hours, should be delivered by a parent/guardian and given to the school nurse or secretary. Any medication found in a student's possession, including his/her backpack or locker, could result in suspension or expulsion. All unauthorized medications will be confiscated.

Please keep in mind that school is not the best place to administer medicines. Doses can be forgotten during the busy school day. If your child's medicine can be administered at home, please do so. Remember, the initial dose of a medication cannot be administered at school.

In order for the school to administer **any** medication to your student, you will need the following:

- *A **Kenton County School District Administration of Medication Permission Form** completed and signed by your child's physician. This form must also be signed by the parent/guardian. This form is available in the school office or first aid room.*
    - *Notes from parents requesting medication to be administered to students will not be accepted.*
    - *We cannot accept telephone permission for medication administration from a physician. Your doctor's office may fax the signed form to the school.*
- *Medication must be in the original container. All prescription medications must have the student's name on the label with directions for administration that match the permission form.*

If the above procedures are not followed, we will not be permitted to administer medication to your student at school.
Medications containing narcotics for pain relief or sedation should not be sent to school. For their own safety, children requiring this level of medication should remain at home until this medication is no longer required during the school day.
All unused medications not picked up from school by a parent within 5 days will be discarded. No medication will be sent home with students.

We appreciate your cooperation in this matter and hope you understand these procedures are for the safety of all of our students.

Reviewed 1.8.19

Kenton County School District Administration of Medication Permission Form

SCHOOL: Simon Kenton High School **PHONE:** 859-960-0117 **FAX:** 859-960-0118

Dear Parent/Guardian,

If medication administration is required during the school day, whether prescription or non-prescription, this form must be completed and signed by both a physician and parent. For any questions, please contact the school nurse.

All medications are kept in the first aid room and must be in the original container with label affixed. For prescription medication, your student's name must be on the label and the label must match the directions on this form. The initial dose of a medication cannot be administered at school.

Pursuant to *KRS 158.834, 158.838, and 158.836*, the Board of Education policy permits a responsible, trained student to carry and/or self administer medication for asthma (inhaler), severe allergic reaction (Epi-pen), seizures (FDA approved for rescue or symptoms) or diabetes (Glucagon) on his/her person for immediate use in a life threatening situation with a written physician's order, parent request, school nurse and principal approvals. We accept the parent request and physician statement. We will permit and assist the student to be responsible, but reserve the right to withdraw the privilege if the student shows signs of irresponsible behavior or there is a safety risk. We will contact the parent as soon as possible in this event.

A new form is required for any changes in medication orders. This form may be faxed to the school to the number listed above.

The duration of this form is for one school year only. SCHOOL YEAR: _____.

Name: _____ Date of Birth: _____ Grade: _____ ALLERGIES: _____

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER

1. Medication: _____ Dosage: _____ Directions: _____
Administration Time: Lunch ____ or _____ Route: _____ Diagnosis/Condition: _____
Possible Side Effects: _____ Duration: Start_____ Stop_____
****In the case of an inhaler, Epipen, FDA approved seizure symptom/rescue medication or Glucagon, student has received training to carry the inhaler or emergency medication and, in my opinion, may ____CARRY and/or ____ SELF ADMINSTER this medication.**
(Physician's Initial) Yes ___

2. Medication: _____ Dosage: _____ Directions: _____
Administration Time: Lunch ____ or _____ Route: _____ Diagnosis/Condition: _____
Possible Side Effects: _____ Duration: Start_____ Stop_____
**** In the case of an inhaler, Epipen, FDA approved seizure symptom/rescue medication or Glucagon, student has received training to carry the inhaler or emergency medication and, in my opinion, may ____CARRY and/or ____SELF ADMINSTER this medication.**
(Physician's Initial) Yes ___

3. Medication: _____ Dosage: _____ Directions: _____
Administration Time: Lunch ____ or _____ Route: _____ Diagnosis/Condition: _____
Possible Side Effects: _____ Duration: Start_____ Stop_____
**** In the case of an inhaler, Epipen, FDA approved seizure symptom/rescue medication or Glucagon, student has received training to carry the inhaler or emergency medication and, in my opinion, may ____CARRY and/or ____SELF ADMINSTER this medication.**
(Physician's Initial) Yes ___

******PARENT/GUARDIAN AUTHORIZATION FOR SELF CARRY/SELF ADMINISTER ONLY******

I request that my child, named above, be permitted to: _____ carry _____ self-administer the above **emergency medication.** I take responsibility for this permission and will ensure the medication is not expired. I understand the medication must be in the original pharmacy container, labeled with name of student, prescribing health care provider, and medication; date of original prescription; strength and dose of medication; and directions for use.

PARENT SIGNATURE	**DATE**	**STUDENT SIGNATURE**	**DATE**

During school hours, I understand teachers, assistants, nurses or other trained school personnel may be administering these medications according to the specified physician's order and District policy. Schools have established individual procedures for where and when the students receive their daily medications. The student has the ultimate responsibility of reporting daily for their medication.

No medications will be sent home with students. All unused medications and medications without orders not picked up from the school by a parent within five (5) days will be discarded.

I give permission for the storage and administration of this medication by trained school personnel accompanying my student on a field trip or school related function in Kentucky and/or other states. In the case of field trips or school related functions, slight variations to the time the medication is administered may also be necessary. Unless indicated otherwise, student may self administer medication with school trained personnel supervision while on a field trip.

I hereby release the Kenton County Board of Education and its employees from any claims or liabilities connected with their reliance on this permission and agree to indemnify, defend and hold them harmless from any claim or liability connected with such reliance.

***Parent's Signature**	Parent's Phone	Date
***Physician's Signature**	Physician's Phone	Date
***Print Physician's Name**	Physician's Address	Fax Number
Principal's Signature (For self-carry only)	School Nurse Signature	Date Form Rec'd in Office

(5/19)

11

HEALTH CONDITIONS REQUIRING EMERGENCY MEDICATION ADMINISTRATION

Student Name_____ Grade_____

School_____

Sport(s) participating in:
Fall: _____
Winter: _____
Spring: _____
Summer: _____

Has your child been diagnosed with any of the medical conditions listed below?

Life-Threatening Allergy	____no	____yes	Is an Epipen Ordered?	____no	____yes
Diabetes	____no	____yes	Is Glucagon ordered?	____no	____yes
Seizures	____no	____yes	Is Diastat ordered?	____no	____yes
Asthma	____no	____yes	Is an Inhaler ordered?	____no	____yes

Other Important Health Information _____
_____

If you've indicated yes on a medical condition, please contact the coach and school nurse for additional information. A *Medication Authorization Form* must be completed for all students requiring medication.

Parent Signature: _____ Date: _____

St. Elizabeth HEALTHCARE
Sports Medicine

AUTHORIZATION FOR TREATMENT & RELEASE OF HEALTH INFORMATION

As (please specify) parent/guardian of _____ (the "Student"), a student at _____ School (the "School") in _____, Kentucky, who desires to participate in extracurricular athletic program(s) of the School (the "Program"), I understand that in the course of competing in the Program or Program-sponsored events the Student may require attention or assistance from an athletic trainer for illness or injury incurred while participating in such Program-sponsored sporting events. I understand that the School has arranged for St. Elizabeth Healthcare to provide such attention and assistance during certain Program-sponsored events and I authorize Student to receive such attention and assistance. I, the undersigned, hereby authorize St. Elizabeth Healthcare to release all necessary medical information about the Student obtained in the course of providing athletic training attention or assistance during Program-sponsored events to the School and its representatives including, but not limited to, coaches, athletic director, team and/or family physician, for the purpose of making determinations regarding the continued participation of the Student in the Program or Program-sponsored sporting events.

I understand that I have the right to revoke this authorization at any time except to the extent St. Elizabeth Healthcare has already acted as a result of this authorization. I further understand that any revocation must be provided in writing to St. Elizabeth Healthcare.

I also understand that when information is used or disclosed based on an authorization, the information may be re-disclosed by the recipient and no longer protected by the Standards for the Privacy of Individually Identifiable Health Information.

This authorization shall expire at the end of the Program's season.

I understand that I have the right to refuse to sign this authorization.

_____ Student's Name

_____ Street/box number

_____ Student's Date of Birth

_____ City, State, Zip Code

_____ Student's Signature (required if student is 18 or over or will turn 18 before program ends)

_____ Student's Telephone Number

_____ Name of Parent or Guardian

_____ Date

_____ Signature of Parent or Guardian

_____ Relationship to Student (Parent, Guardian, etc.)

St. Elizabeth HEALTHCARE Sports Medicine

SK Sports Medicine

Commonwealth ORTHOPAEDIC CENTERS

Student Information:

Last Name _____ First Name _____ Middle Initial ____

Sport/(s) _____ Grade _____ Date of Birth _____

Address _____ City _____ Zip _____

Home Phone: _____ Student Cell Phone: _____

Parents Information:

Mothers Name: _____

Address: _____

_____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email: _____

Fathers Name: _____

Address: _____

_____

Home Phone _____

Work Phone: _____

Cell Phone: _____

Email: _____

Emergency Contact: In case we are unable to reach a parent please provide an alternative emergency contact.

Name: _____ Phone Number: _____

Insurance Information:

Policy Holder: _____

Insurance Company _____

Policy ID Number _____

Family Physician: _____

Policy Holders Date of Birth _____

Employer _____

Group Number _____

Does your insurance require referral? YES / NO

Athletes Medical History:

Does the athlete have any life threatening allergies? Yes / No : _____

Will the athlete need to take any medications during the season? Yes / No: please list: _____

_____

Does the athlete have any special medical conditions that I need to be aware of? Yes / No: please list:

_____

_____

In the event that an athletic injury should occur to the above named athlete, I give my permission for them to receive care from the athletic trainer and/or staff from St. Elizabeth Sports Medicine and Commonwealth Orthopedics. In addition, I give consent for the athletic trainer/staff of St. Elizabeth Sports Medicine & Commonwealth to provide health information (i.e. information regarding the athlete's injuries and/or health history) to coaches, physicians, or other school personnel when it is necessary for the care and treatment of said athlete's injuries.

Furthermore, in the event that a medical emergency should occur and I cannot be contacted I give my permission for a school representative to arrange for ambulance service to the nearest medical facility. I also give permission for the staff of the medical facility to render any treatment which is considered necessary for that athlete's well-being.

Parents Signature: _____ Date: _____

Football only

THE KENTON COUNTY SCHOOL DISTRICT

FOOTBALL HELMET WAIVER FORM

Parent / Guardian initial next to each item

- I hereby acknowledge that I have been offered a District-owned football helmet for my use during the _____ (year) football season. However, I have declined this offer and instead, have elected to privately purchase a football helmet, at my sole expense. ____
- I understand that in order for The Kenton County School District to permit me to utilize my privately purchased football helmet for The Kenton County School District's Football Program my new helmet shall bear the permanent "meets NOCSAE standards" seal and the "NOCSAE" logo. ____
- I understand that in order for The Kenton County School District to permit me to utilize my privately purchased football helmet for The Kenton County School District's Football Program in any subsequent season, I shall submit my helmet to the District, each year, for the required reconditioning and recertification by a NOCSAE licensed agency, at such a time specified by the Head Coach and/or Athletic Director. ____
- I understand that in order for The Kenton County School District to permit me to utilize my privately purchased football helmet for The Kenton County School District's Football Program my helmet shall be properly fitted to me and inspected to be NOCSAE compliant, including but not limited to the age and condition of the helmet, by The Kenton County School District's Awarded Football Helmet Reconditioning Bid Vendor. ____
- I acknowledge that prior to my use, The Kenton County School District has the right to inspect my helmet for items including but not limited to damage to the helmet shell or liner, holes, loose hardware and/or loose face masks. ____
- I understand that in order for The Kenton County School District to permit me to utilize my privately purchased football helmet for The Kenton County School District's Football Program I shall provide a repair kit including spare parts to the school's trainer for all practices/games.
- I acknowledge that The Kenton County School District has the right to prohibit the use of my privately purchased helmet, in its discretion, should The Kenton County School District's Designee determine that my football helmet does not meet the above criteria or is otherwise deemed by The Kenton County School District to be unsafe and/or improper for my use. In such event, I understand that The Kenton County School District shall provide me with a District-owned football helmet at no cost to me. ____

I understand and acknowledge that no helmet can prevent all head or neck injuries a player might receive while participating in any practice, contest or game. ____

I understand and acknowledge that improper or illegal use of a helmet can result in severe head or neck injuries, concussion, paralysis, or death to me and/or my opponent. ____

Football only

I understand that The Kenton County School District may remove me from any game, contest, practice or other activity, should I demonstrate any signs of injury, including but not limited to, head injury or concussion. ____

I hereby acknowledge that other than the required reconditioning and/or recertification of my privately purchased football helmet by The Kenton County School District, I remain solely responsible for my privately purchased helmet, including but not limited to compliance with the applicable helmet warranty(ies), proper fitting of my helmet, remediation of any damage and/or necessary repairs, and proper care/maintenance of my football helmet. ____

I hereby release The Kenton County School District, Superintendent of Schools, individually and in his/her official capacity, The Board of Education of the Kenton County School District, its members, individually and in their official capacities, or any of the District's employees, agents, or independent contractors, from any liability, claim, suit, or expense including, but not limited to, negligence, for any injury or harm which may result from my use or purchase of a privately purchased football helmet. ____

Parent/Guardian Acknowledgement:

I have carefully read and accept the above Helmet Waiver and I acknowledge that I have discussed this Helmet Waiver with my child.

Parent(s)/Guardian(s) Signature: _____ Date: _____

Student Name: _____ I have carefully read and accept the above Helmet Waiver.

Student Signature: _____ Date: _____

Optional Supplemental Insurance
* must purchase if no insurance *

K-12 Student Accident Insurance

Enroll Online

www.studentinsurance-kk.com

Worried about paying for your child's medical care if an accident should happen? K&K's student accident insurance can help. If you don't have health care coverage, student accident insurance is vital. If you are covered by a health care plan, student accident insurance can fill the gap by paying deductibles and copays that may cause financial harm to your family.

K-12 Accident Plans available through your school:

- *At-School Accident Only*
- *24-Hour Accident Only*
- *Extended Dental*
- *Football*

How to Enroll Online

Enrolling online is easy and should take only a few minutes. Go to **www.studentinsurance-kk.com** and click the **"Enroll Now"** button.

1. Start by telling us the name of the school district and state where your child attends school.
2. We'll request each student's name and grade level.
3. You'll see the available plans and their rates. Select your coverage and continue to the next step.
4. We'll request information about you, like your name and email address.
5. Next, you'll enter information about the child or children to be covered.
6. Enter your credit card or eCheck payment information.
7. Finally, print out a copy of the confirmation for your records.

For further details of the coverage including costs, benefits, exclusions, any reductions or limitations and the terms under which the policy may be continued in force, please refer to www.studentinsurance-kk.com. Student is able to purchase the coverage only if his/her school district is a policyholder with the insurance company.

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¿Le preocupa tener que pagar la atención médica de su hijo si ocurre un accidente? El seguro contra accidentes para estudiantes de K&K puede ayudarlo. Si no tiene cobertura de seguro de salud, un seguro contra accidentes para estudiantes es fundamental. Si cuenta con la cobertura de un plan de atención de la salud, un seguro contra accidentes para estudiantes puede cubrir la brecha y pagar los deducibles y los copagos que podrían generar un perjuicio económico para su familia.

Planes de cobertura en caso de accidente para K-12 disponibles a través de su escuela:

- *Sólo accidentes en la escuela*
- *Sólo accidentes, 24 horas*
- *Dental extendido*
- *Fútbol*

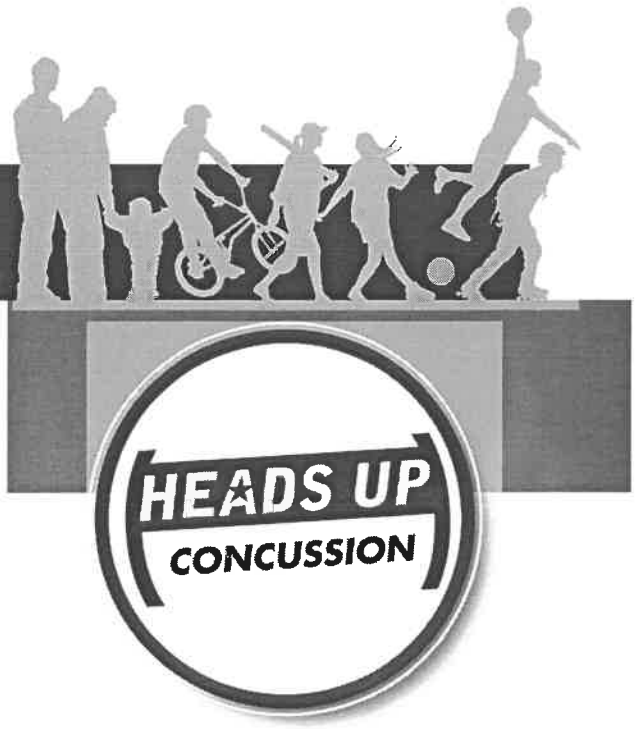
Cómo inscribirse en línea

Inscribirse en línea es fácil y sólo le tomará unos pocos minutos. Visite **www.studentinsurance-kk.com** y haga clic en el botón **"Enroll Now"** ("Inscribirse ahora").

1. Comience por decirnos el nombre del distrito escolar y el estado en el que su hijo(a) va a la escuela.
2. Solicitaremos el nombre y el grado de cada uno de los estudiantes.
3. Verá los planes disponibles y sus tarifas. Seleccione su cobertura y continúe con el siguiente paso.
4. Le solicitaremos información sobre usted, como su nombre y dirección de correo electrónico.
5. Después, ingresará la información acerca del niño o niños que recibirá(n) cobertura.
6. Ingrese la información de pago de su tarjeta de crédito o eCheck.
7. Finalmente, imprima una copia de la confirmación para sus registros.

Para obtener más detalles sobre la cobertura, incluidos costos, beneficios, exclusiones y reducciones o limitaciones y los términos en virtud de los cuales esta póliza podría continuar en vigencia, consulte www.studentinsurance-kk.com. Los estudiantes pueden comprar la cobertura únicamente si su distrito escolar es titular de una póliza con la compañía de seguros.

CONCUSSION FACT SHEET FOR PARENTS



WHAT IS A CONCUSSION?

A concussion is a type of traumatic brain injury. Concussions are caused by a bump or blow to the head. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

You can't see a concussion. Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If your child reports any symptoms of concussion, or if you notice the symptoms yourself, seek medical attention right away.

WHAT ARE THE SIGNS AND SYMPTOMS OF CONCUSSION?

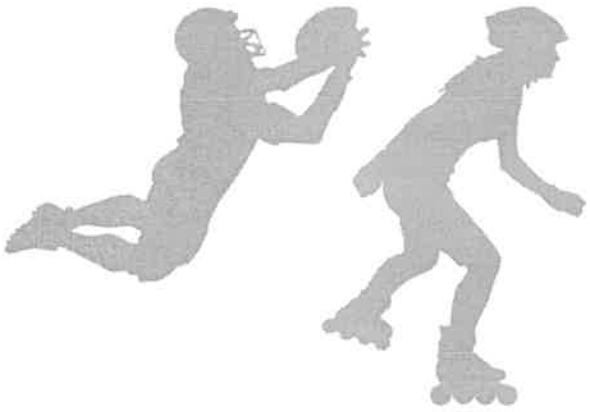
If your child has experienced a bump or blow to the head during a game or practice, look for any of the following signs of a concussion:

SYMPTOMS REPORTED BY ATHLETE:

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light
- Sensitivity to noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Just not "feeling right" or is "feeling down"

SIGNS OBSERVED BY PARENTS/ GUARDIANS:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes



DANGER SIGNS

Be alert for symptoms that worsen over time. Your child or teen should be seen in an emergency department right away if s/he has:

- One pupil (the black part in the middle of the eye) larger than the other
- Drowsiness or cannot be awakened
- A headache that gets worse and does not go away
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Difficulty recognizing people or places
- Increasing confusion, restlessness, or agitation
- Unusual behavior
- Loss of consciousness (even a brief loss of consciousness should be taken seriously)

WHAT SHOULD YOU DO IF YOU THINK YOUR CHILD HAS A CONCUSSION?

1. SEEK MEDICAL ATTENTION RIGHT AWAY
   A health care professional will be able to decide how serious the concussion is and when it is safe for your child to return to regular activities, including sports.
2. KEEP YOUR CHILD OUT OF PLAY.
   Concussions take time to heal. Don't let your child return to play the day of the injury and until a health care professional says it's OK. Children who return to play too soon - while the brain is still healing - risk a greater chance of having a second concussion. Repeat or later concussions can be very serious. They can cause permanent brain damage, affecting your child for a lifetime.
3. TELL YOUR CHILD'S COACH ABOUT ANY PREVIOUS CONCUSSION.
   Coaches should know if your child had a previous concussion. Your child's coach may not know about a concussion your child received in another sport or activity unless you tell the coach.

HOW CAN YOU HELP YOUR CHILD PREVENT A CONCUSSION OR OTHER SERIOUS BRAIN INJURY?

- Ensure that they follow their coach's rules for safety and the rules of the sport.
- Encourage them to practice good sportsmanship at all times.
- Make sure they wear the right protective equipment for their activity. Protective equipment should fit properly and be well maintained.
- Wearing a helmet is a must to reduce the risk of a serious brain injury or skull fracture.
  - However, helmets are not designed to prevent concussions. There is no "concussion-proof" helmet. So, even with a helmet, it is important for kids and teens to avoid hits to the head.

HOW CAN I HELP MY CHILD RETURN TO SCHOOL SAFELY AFTER A CONCUSSION?

Children and teens who return to school after a concussion may need to:

- Take rest breaks as needed
- Spend fewer hours at school
- Be given more time to take tests or complete assignments
- Receive help with schoolwork
- Reduce time spent reading, writing, or on the computer

Talk with your child's teachers, school nurse, coach, speech-language pathologist, or counselor about your child's concussion and symptoms. As your child's symptoms decrease, the extra help or support can be removed gradually.

HEADS UP

JOIN THE CONVERSATION www.facebook.com/CDCHeadsUp

TO LEARN MORE GO TO >> WWW.CDC.GOV/CONCUSSION

Content Source: CDC's Heads Up Program. Created through a grant to the CDC Foundation from tl
National Operating Committee on Standards for Athletic Equipment (NOCSAE

CONCUSSION

A FACT SHEET FOR STUDENT-ATHLETES

WHAT IS A CONCUSSION?

A concussion is a brain injury that:

- Is caused by a blow to the head or body.
  - From contact with another player, hitting a hard surface such as the ground, ice or floor, or being hit by a piece of equipment such as a bat, lacrosse stick or field hockey ball.
- Can change the way your brain normally works.
- Can range from mild to severe.
- Presents itself differently for each athlete.
- Can occur during practice or competition in ANY sport.
- **Can happen even if you do not lose consciousness.**

HOW CAN I PREVENT A CONCUSSION?

Basic steps you can take to protect yourself from concussion:

- Do not initiate contact with your head or helmet. You can still get a concussion if you are wearing a helmet.
- Avoid striking an opponent in the head. Undercutting, flying elbows, stepping on a head, checking an unprotected opponent, and sticks to the head all cause concussions.
- Follow your athletics department's rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.
- Practice and perfect the skills of the sport.

WHAT ARE THE SYMPTOMS OF A CONCUSSION?

You can't see a concussion, but you might notice some of the symptoms right away. Other symptoms can show up hours or days after the injury. Concussion symptoms include:

- Amnesia.
- Confusion.
- Headache.
- Loss of consciousness.
- Balance problems or dizziness.
- Double or fuzzy vision.
- Sensitivity to light or noise.
- Nausea (feeling that you might vomit).
- Feeling sluggish, foggy or groggy.
- Feeling unusually irritable.
- Concentration or memory problems (forgetting game plays, facts, meeting times).
- Slowed reaction time.

Exercise or activities that involve a lot of concentration, such as studying, working on the computer, or playing video games may cause concussion symptoms (such as headache or tiredness) to reappear or get worse.

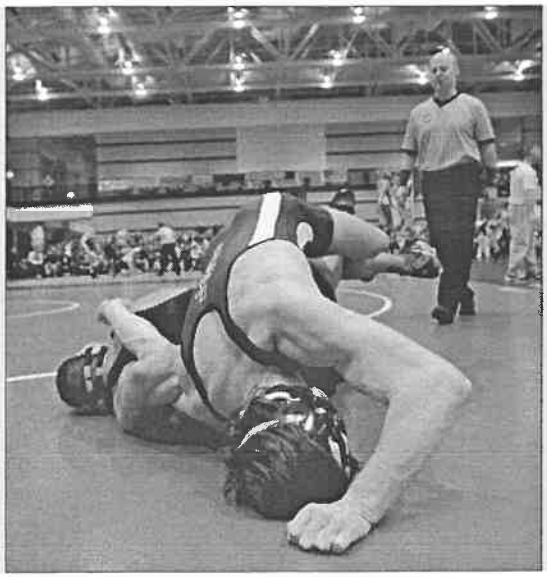
WHAT SHOULD I DO IF I THINK I HAVE A CONCUSSION?

Don't hide it. Tell your athletic trainer and coach. Never ignore a blow to the head. Also, tell your athletic trainer and coach if one of your teammates might have a concussion. Sports have injury timeouts and player substitutions so that you can get checked out.

Report it. Do not return to participation in a game, practice or other activity with symptoms. The sooner you get checked out, the sooner you may be able to return to play.

Get checked out. Your team physician, athletic trainer, or health care professional can tell you if you have had a concussion and when you are cleared to return to play. A concussion can affect your ability to perform everyday activities, your reaction time, balance, sleep and classroom performance.

Take time to recover. If you have had a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have a repeat concussion. In rare cases, repeat concussions can cause permanent brain damage, and even death. Severe brain injury can change your whole life.



IT'S BETTER TO MISS ONE GAME THAN THE WHOLE SEASON. WHEN IN DOUBT, GET CHECKED OUT.

For more information and resources, visit www.NCAA.org/health-safety and www.CDC.gov/Concussion.

NCAA CDC