Name:_____
Sport(s):_____
Graduation Year_____

IMPORTANT

Return the following Sports Medicine packet of information to the Athletic Trainer on or before your first practice.ONE PACK PER SCHOOL YEAR Failure to do so may result in a loss of practice/ participation time.

WHS ATHLETE MEDICAL FORMS

Head Athletic Trainer: Lauren Will
Washington High School
300 Washington Patriots Dr
Charles Town, WV. 25414
(304) 885-5110

WHS Athletic Consent Form

Grade: 9 10 11 12

Athlete Name:

_____

By Signing Below I/WE Certify That:

A. Statement of Risk:

I,_____am aware of and accept the risk of injury associated with
(Athlete Name)

the high school activities in which I will be participating. I will do my part to reduce the risk of injury by following the advice of the team physician, athletic trainer, teacher and/or coach concerning the care of any injuries incurred while participating in sports for Jefferson County Schools.

B. Parental Consent to Treat:

I. I give permission to the attending physician and/or athletic trainer, the approved activities to carry out such emergency diagnostic and therapeutic procedure as may be necessary for my child. I also permit such procedure to be carried out by one of the local hospitals in the event that my child has been sent or taken there for emergency care. I am also informed that my child will be taken to the closest most available hospital based on local EMS protocols. I understand this does not mean the absolute closest, but rather one that has the availability to see my child with the least wait involved. In the event of a serious illness or injury, I understand that an attempt will be made to contact me. If I cannot be contacted treatment or referral will be made in the best interest of the above named student._____(Parent/ Guardian Initial)

II. Permission is hereby granted to the Washington High School Athletic Trainer, the approved health care provider, to proceed with any use of modalities (i.e. Ice, Moist Heat, UltraSound, Electric Stimulation), for the care, treatment and rehabilitation of the above named student who is an athlete participating in JHS athletic events. All modalities will be used under the orders of the Washington High School Team Physician and will only be administered by the Washington High School Certified Athletic Trainer. _____(Parent/ Guardian Initial)

III. Permission is herby granted to the Washington High School Athletic Trainer, the approved health care provider to proceed with any necessary evaluation, minor medical treatment, and/or rehabilitation for the above named student participating in WHS athletic events._____(Parent/ Guardian Initial)

C. Permission To Compete/ Statement of Liability For Participation in Athletics

Permission is given for my son/daughter or ward to participate in interscholastic sports. It is understood that time after school will be required for practice or competition. The school will provide suitable supervision at practice, games both home and away, and travel supervision while participating in games or practices not held on site at the school. Beyond this point of supervision, the school cannot assume responsibility for injuries. In exchange for the opportunity to compete in sports, I freely and fully waive any claim by me, my spouse/ significant other, or my son or daughter against Washington High School and its employees arising from a sports related injury or transportation to and from a sporting event.

I_____**(Parent/ Guardian signature), understand that, although the coaching staff, sports medicine staff, and administration are taking every precaution to ensure that my child remain safe and injury/ illness free while under their supervision, there is still a possibility of injury or illness possible at any time, to no fault of the staff through correct, responsible and safe participation in sport.**_____**(Athlete Initial)**

A student is financially responsible for the replacement cost of athletic equipment (both team and sports medicine related) and uniforms which are not returned within ten (10) days of the close of the season. In addition, it is recognized that the student must comply with the eligibility requirements governing Washington High School Athletic Programs.

Signature of Parent/ Guardian: _____

Relationship to the Athlete:_____Date:_____/_____/_____

WHS Athletic Training Room Rules:

The following rules are in effect for the Washington High School Athletic Training Room, to ensure that student-athletes are served efficiently, and anyone not following these rules will be asked to leave without receiving treatment.

1. The athletic training room is first and foremost a healthcare facility and should be treated in such a manner. If you are NOT receiving treatment or being taped, you will be asked to leave.

   The athletic training room is NOT A LOUNGE!!

2. The athletic training room is an equal access facility, and the athletic trainer will make every effort to treat student-athletes on a first come first serve basis, except for emergencies. Exceptions to this include:
   - One student- athlete has a practice time earlier than another.
   - Athletes preparing for a game are given priority over athletes that have practice.
   - **Emergency situations take precedence over all other situations.**

3. No more than four students are permitted in the athletic training room at one time. In the same respect, **all student athletes are required to sign-in prior to receiving any treatment and must be wearing a face covering for the duration of their visit, unless otherwise instructed.**

4. The athletic training room is a coeducational facility. Minimum dress of shirts and shorts is required at all times unless removal is necessary for medical treatment. Absolutely NO sports bras or bare midriffs are allowed!! All student athletes must be changed into appropriate clothing prior to entering the training room, and should do so by using only the appropriate locker room facilities.

5. No cleats, track spikes, or other outdoor shoes are permitted in the athletic training room. Shoes necessary for lower extremity rehabilitation are the only exception (ex. tennis shoes).

6. No personal belongings (backpacks, gym bags, purses, etc.) and/or athletic equipment (such as helmets, shoulder pads, sticks/bats, etc.) are permitted in the athletic training room, and are to be left outside the athletic training room while the student is being seen by the Athletic Trainer.

7. Horseplay, profanity, and/or derogatory/ abusive language will not be tolerated at any time!!

8. Student athletes are not permitted to treat themselves and/ or dictate their own treatments. All treatments, braces, and taping procedures will NOT be administered unless deemed necessary by the Athletic Trainer or physician note/ instruction.

WHS Athletic Training Room Rules:

9. DO NOT take or use the athletic training room equipment or supplies (especially tape) without permission. This includes, but not limited to, all student athletes, team managers, and coaches. If certain supplies have been used from the team's medical kit, please be sure to notify the athletic trainer in a timely manner so that she may replace the supplies as soon as possible.

10. Please remember that all athletic training room supplies and the supplies provided in team medical kits are to be used **ONLY** for the treatment of injuries or wounds sustained during practice and/or athletic competition. (Under no circumstances should pre-wrap be used as a headband or athletic tape be used for sports equipment, to hold shin guards,
socks, and/or shoelaces in place.)

Improper use of athletic training supplies may result in the limitation of or the cessation of distribution of said supplies.

Ask before taking anything!!!

11. All equipment (ace wraps, slings, braces, crutches, etc.) must be returned in a timely manner once they are no longer needed. (All equipment must be signed out and signed back in when use of equipment is no longer necessary, by both the athlete and the athletic trainer.)

12. Athletes are not permitted to be in the athletic training room without direct supervision from the athletic trainer, a member of the athletic department staff, a teacher, or a
member of administration.

13. No medications are to be dispensed to a student athlete at any time by the athletic trainer or any member of a team's coaching staff.

By signing below you understand the importance of following the rules of the Athletic Training Room at all times and promise to facilitate good behavior and uphold the proper procedures asked of you by the Athletic Training and Coaching Staff at all times.

Athlete Printed Name: _____

Athlete Signature:_____Date:_____/____/_____

Guidelines for Athletic Injury Reporting and Referral

Sports injuries are an unfortunate consequence of athletic participation. In order to provide the best possible care for these injuries, the following procedures have been established:

Reporting of Athletic Injuries:

1. Any sports- related injury that occurs during participation in athletics sponsored by Washington High School should be reported to the athlete's coach immediately. If the athlete is unable to return to play, or if the injury requires additional care, the athlete must see the Athletic Trainer after activity, or as soon as practical during the next school day.

2. The Athletic Trainer will evaluate the injury and, based on the evaluation, make a determination as to appropriate course of care for the athlete. Treatment will be based on established protocols. In most cases, injuries are minor in nature and the athlete can be successfully treated in the Athletic Training Room. If the injury is more extensive or will require further medical evaluation by a physician, the athlete's parents will be contacted.

Physician Referral:

1. If you feel an athletic injury requires the evaluation or care of a doctor, we suggest that you contact us prior to seeing your physician of choice. It is important for the follow-up care of your child that we have open communication with your child's physician. It is also important that we know the diagnosis and instructions in order to provide the following-up care necessary. We have established relationships with a number of local doctors, and would be happy to suggest those with sports medicine expertise.

2. ***If your child is seen by a physician for a sports-related injury OR illness, he/she will not be able to return to participation without a written release from their physician.*** Without the permission from the physician we have no way of confirming the diagnosis, what treatment we may provide, whether or not an athlete is actually cleared to return to participation or if there are limitations to his/her participation.

3. Any athlete with an injury that causes a loss of more than 3 days of sport participation (practice and/or game) that did not result from WHS sport participation or is absent from school due to illness, he/she **will be REQUIRED** to receive a signed physician's clearance before returning to team activities.

If you have ANY questions regarding the care of your child's injury, please contact the Athletic Training Staff.

I_____ the parent/ guardian of_____ understand the
(Print Parent/ Guardian Name) (Print Student-Athlete Name)

importance of communication with the WHS athletic and athletic training staff in regards to my son/daughter medical status. I will do my part to facilitate that my student athlete reports any and all injury/ illness to the athletic trainer in a timely manner.

Signature of Parent/ Guardian:_____ Date:_____/_____/_____

Signature of Student Athlete:_____ Date:_____/_____/_____

HIPAA Release Form

Jefferson County Athletic Training Department

HIPAA stands for Health Insurance Portability and Accountability Act and was created to increase the privacy of an individual's personal health information. It affects all those who are in contact with medical records or personal health information. Under this law, Certified Athletic Trainers (ATCs) will no longer be able to speak to anyone in regards to an injury or condition unless a release is signed.

I am allowing **FULL DISCLOSURE** of my student-athlete's personal health information in regards to any athletic injury he/she may sustain while participating in high school athletics at Washington High School. I understand that by allowing partial or no disclosure of my personal health information I may forfeit my participation in sports at Washington High School.

All of the following individuals may be told about my conditions as deemed medically necessary by the Athletic Trainer:

- Parents/Guardians of the athlete
- Sports Medicine Staff (Could include, but not limited to Student Trainers, WVU Medicine Physicians/ Medical Students, and/or Pivot Physical Therapists or PTA's)
- School Insurance Agents
- Physicians and Doctor's Office Staff
- Coaches
- School Administration

Athlete's Name (please print): _____

Athlete's Signature: _____ Date: ____/____/____

Parent/Guardian Signature: _____ Date: ____/____/____

Relationship to athlete: _____

WHS Athletic Training Department Emergency Medical Authorization Form/ Health Insurance Information

Athlete's Name: _____ Male / Female

(Last) (First) (Middle) Date of Birth: _/_____/_____

Grade for Current School Year: Freshman Sophomore Junior Senior

Current Physical Address: _____

_____ _____ _____

(City) (State) (Zip Code)

Current Home Phone Number: _____

Fall Sport: _____ Winter Sport: _____

Spring Sport: _____

The following information is needed by the athletic training staff in the event we need to send your child to a hospital for an emergency.

Parent/ Guardian Name: _____ Relationship: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ Number you wish to be called first: **Home Work Cell**

(Please Circle One)

Parent/ Guardian Name: _____ Relationship: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ Number you wish to be called first: **Home Work Cell**

(Please Circle One)

Family Physician's Name: _____, MD or DO (circle one)

Address: _____ Telephone #: _____

Student's Allergies: _____

Student's health Condition(s) of which an emergency physician or other medical personnel should be aware: _____

_____

_____

Student' Prescription Medications and Conditions of which they are being prescribed: _____

Insurance Information:

Primary Health Insurance Company: _____

Policy Number:_____Group Number: _____

Does your Insurance Company Require:

A second opinion for Surgery: _____

Pre Authorization for Services: _____

Secondary Insurance Company: _____

Policy Number:_____Group Number: _____

Consent to Treat:

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary, and (2) the transfer of my child to any hospital accessible. This authorization does not cover major surgery unless medical options of two other licensed physicians concurring in the necessity of surgery are obtained prior to the performance of such surgery.

Signature of Parent/ Guardian:_____Date:____/____/_____

Refusal to consent:

I **DO NOT** give consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following actions: **(If no actions are list, this signature will be considered invalid)**

_____

_____

_____

Signature of Parent/ Guardian:_____Date:____/____/_____

Confidentiality Statement:

The information on this form shall be treated as confidential by school personnel. It may be used by the school's athletic administration, coaches and medical staff to determine athletic eligibility, to identify medical conditions, injuries, ad to promote safety and injury prevention. In the Event of an emergency, the information contained in this for may be shared with emergency medical personnel. Information about an injury or medical condition will not be shared with the public or media without written consent of the parent(s) or guardian(s).

Parent's/ Guardian's Signature:_____Date:____/____/____

Consent for Cognitive Testing and Release of Information

I (Name of parent/ guardian)_____give my permission for (name of child) _____(child's date of birth)_____/_____/_____to have a baseline and post-concussion ImPACT (Immediate Post-Concussion Assessment and Cognitive Testing) administered by Jefferson County Schools. I understand that my child may need to be tested more than once post-injury, depending upon the results of the test, as compared to my child's baseline test, which will be kept on file at the school. I understand there is no charge for the testing performed at the school. Jefferson County Schools may release the ImPACT (Immediate Post Concussion Assessment and Cognitive Testing) results to my child's primary care physician, neurologist, WVU Medicine or other treating physician, as indicated below. I understand that general information about the test data may be provided to my child's guidance counselor and teachers, for the purpose of providing temporary academic modifications, if necessary.

ImPACT is a computerized exam utilized in many professional, collegiate, and high school sports programs across the country to diagnose and manage concussions. If an athlete is believed to have suffered a head injury during competition, ImPACT is used to help determine the severity of head injury and when the injury has fully healed.

The computerized exam is given to athletes before beginning contact sport practice or competition. This non-invasive test is set up in "video-game" type format and takes about 20-30 minutes to complete. It is simple, and actually many athletes enjoy the challenge of taking the test. Essentially, the ImPACT test is a preseason physical of the brain. It tracks information such as memory, reaction time, speed, and concentration. It, however, is not an IQ test.

If a concussion is suspected, the athlete will be required to re-take the test. Both the preseason and post-injury test data is interpreted by physicians certified in sport concussion management with ImPACT and shared with your doctor, to help evaluate the injury. The test data will enable these health professionals to determine when return-to-play is appropriate and safe for the injured athlete.

I wish to stress that the ImPACT testing procedures are non-invasive, and they pose no risks to your student-athlete. We are excited to implement this state-of-the-art program given that it provides us the best available information for managing concussions and preventing potential brain damage that can occur with multiple concussions. The Jefferson High School administration, coaching, and athletic training staffs are
striving to keep your child's health and safety at the forefront of the student athletic experience. Please return the attached page with the appropriate signatures. If you have any further questions regarding this program please feel free to contact me at lwill@pivoths.com.

Signature of Parent/ Guardian:_____Date:_____/_____/_____

Please Print the Following Information:

Name of Family Physician: _____

Name of Practice: _____

Phone Number: _____

Athletic Pre-Participation &
Concussion Parent-Athlete Education

I _____, the parent/guardian of student-athlete at Washington High School, acknowledge that I have received information on all of the following:

- **The definition of a concussion**
- **The signs and symptoms of a concussion to observe for or that may be reported by my athlete:**

• *Headache or "pressure" in head*	• *Appears dazed or stunned*
• *Nausea or vomiting*	• *Is confused about assignment or position*
• *Balance Problems and/or dizziness*	• *Forgets an instruction*
• *Double or blurry vision*	• *Is unsure of game, score, or opponent*
• *Sensitivity to light*	• *Moves clumsily*
• *Sensitivity to noise*	• *Answers questions slowly*
• *Feeling sluggish, hazy, foggy, or groggy*	• *Loses Consciousness (even briefly)*
• *Concentration (inability to focus) or memory problems*	• *Shows mood, behavior, or personality changes*
• *Confusion/ Disorientation*	• *Can't recall events prior to the hit or fall*
• *Does not "feel right" or is "feeling down"*	• *Can't recall events after the hit or fall*
• *Excessive Drowsiness*	• *Vacant stare, 'glassy eyed'*
	• *Emotional Lability*
	• *Slurred/ incoherent speech*

- **How to help my athlete prevent a concussion**
- **What to do if I think my athlete has a concussion, specifically, to seek medical attention right away, keep my athlete out of play, tell the coach about a recent concussion, and report any concussion and/or symptoms to the Athletic Trainer *IMMEDIATELY*.**

Parent Guardian: Date:_____/_____/_____

_____

(Signature)

Date:_____/_____/_____

Parent Guardian:

_____

(Print)

Student Athlete:_____Date:_____/_____/_____

(Signature)

Student Athlete:_____Date:_____/_____/_____

(Print)

WHS ATHLETIC DIRECTOR QUESTIONNAIRE

This questionnaire is to be completed in FULL by each person trying out for athletics at Washington High School. Please print, use full names (no nick names) and fill in all questions. Submit this form when finished. It is necessary that a form be completed for each sport that one tries out for throughout the school year.

1. Enter your Full Name (Last, First, Middle):*_____

2. Enter today's date (mm/dd/yy):*____ / ____/ ____

3. Enter your Student ID#:*_____

4. Sport:*_____

5. Enter your Age:*_____

6. Enter your Birth Date (mm/dd/yy):*____ / ____ / ____

7. Check your grade level:*

   9 10 11 12

8. Enter the year you entered WHS:* 20____

9. Enter the City and State of Birth:* _____, _____

10. Enter Father's Name: _____

11. Enter Mother's Name: _____

12. Enter Current Address:*_____, _____, _____, _____

    Street City State Zip

13. Do your parents live in Jefferson County? (Washington High School Zone)*

    Yes No

14. What School did you attend school last semester?*_____

To be eligible, you must:

1. Have passed four (4) subjects the preceding semester (2 core classes)

2. Have a C (2.0 grade point average) the preceding semester for all classes

3. Have a Birth Certificate on file in the school office.

4. Have a Physical Exam Form on file in the trainer's room.

5. Have an Insurance Release Form on file with the coach and trainer.

15. Student Signature and Date:*_____ ____ / ____ / ____

16. Parent Signature and Date:*_____ ____ / ____ / ____

WHS Online Insurance Release Form

INSURANCE RELEASE FORM

Release to: Board of Education of Jefferson County, West Virginia

1. We, the undersigned parents/guardians of:*_____

2. Sport or Activity:*_____

3. Check One:*

_____Hereby warrant to the Board of Education of Jefferson County that we have in force a health insurance policy which will reimburse said child for medical expenses which they may incur by reason of any damage or injuries sustained by them.

_____DO NOT have in force such insurance but we warrant that we are financially able to pay any medical expenses for any injuries that may be incurred by said child during their participation in athletics in the schools of Jefferson County, West Virginia.

4. Given under our hands on this date:*_____/_____/_____

5. Signature of Parent (Guardian):*_____

6. Signature of Parent (Guardian):*_____

Because of the dangers of participating in the above activity, I recognize the importance of listening to and following all of the coach's instruction and warnings regarding playing techniques, training methods, rules of the sport and other team rules. I also recognize the importance of reading and adhering to all written instructions and written warnings regarding playing techniques, training methods, rules of the sport and other team rules. I understand that all instructions and warnings, verbal and written, are incorporated by reference into this agreement and I hereby expressly promise to obey all such instructions and warnings given me by my coaches.

7. Athlete:*_____

8. Sport:*_____

9. Date:*_____/_____/_____

Parental completion of this form also serves as permission for student participation in the athletic program and/or out of season conditioning.

Washington High School

Medical Card For Student Athlete

300 Washington Patriot Dr.

This card should be kept on file in the medical kit for each sport the athlete participates in. It should accompany the athlete to the doctor or hospital when medical attention is required.

Student Name_____

Parent Name_____

Home Address_____

Home #_____

Date of Birth_____

Alternate #_____

Family Physician_____

Physician #_____

Hospital Preference_____

Allergies_____

Current Medications_____

Medical History/ Existing Conditions_____

Medicine Administered at Site_____

Insurance Information:

Does your Son/ Daughter have medical insurance?

If yes, name and phone number of insurance company:

_____

Policy # for insurance:_____

Release for treatment:

I hereby give permission to the attending physician or hospital to administer appropriate medical treatment in the event I cannot be reached.

_____

Signature, Parent/Guardian

Date