

2018-19 Ticket-to-Play Time Line

In order to try out for any sports your ***Ticket-To-Play*** forms need to be complete. The website will list dates and tryout times for individual sports.

- If you do not have a completed packet turned in you will not be able to try-out.
- Under state law all students trying out for a sport must have medical insurance.
- Fall Sports deadline to turn in the completed packet is June 1, 2018
- Winter Sports deadline to turn in the completed packet is November 1, 2018
- Spring Sports deadline to turn in the completed packet is February 1, 2019

The Poway Unified School District (PUSD) is an equal opportunity employer/program and is committed to an active Nondiscrimination Program. PUSD does not discriminate on the basis of race, color, national origin, sex, sexual orientation, ethnic group identification, ancestry, religion, gender, gender identification, mental or physical disability. All course offerings, student clubs, and extracurricular activities are open to all students. For more information, please contact Tracy Hogarth, Associate Superintendent, Personnel Support Services, Poway Unified School District, 15250 Avenue of Science, San Diego, CA 92128-3406.



POWAY UNIFIED SCHOOL DISTRICT ATHLETIC SCREENING HISTORY & PHYSICAL EXAM

Del Norte HS Mt. Carmel HS Poway HS Rancho Bernardo HS Westview HS

Student Name:	Student ID#:	Date of Birth:
Sport(s):	<input type="checkbox"/> Male <input type="checkbox"/> Female	Grade:
Address:	City/Zip:	Graduating Year:
Parent Name/Cell #:	Home Phone:	

EXPLANATION OF SCREENING PHYSICAL

I realize that the medical evaluations performed are only screens in order to evaluate general health, to disclose existing problems, and to determine my son or daughter's dynamic ability to participate in a given sport so that obvious conditions which might be damaged or aggravated by competitive sports can be found, evaluated and treated so as to prevent further injury. This examination does not guarantee against injury. Parent Initials _____ Student/Athlete Initials _____

AWARENESS OF RISK

STUDENT AND PARENT: I am aware that playing/practicing sports can be a dangerous activity involving many risks of injury. I understand that the risks of participation include, but are not limited to, death, serious neck and spinal cord injuries that may result in complete or partial paralysis, brain damage, serious internal injury to virtually any internal organs, bones, joints, muscles, tendons, or any other aspect of the skeletal system, and serious injury or impairment to other aspects of my body, general health and well-being. I understand that the risks of participation may result not only in serious injury, but in impairment of my future ability to earn a living, to engage in other business, social and recreational activities, and generally to enjoy a good life. Because of the dangers of participating in sports, I recognize the importance of following coach instructions regarding playing techniques, training, equipment and other team rules, etc. both in competition and practice and agree to obey such instructions. Parent Initials _____ Student/Athlete Initials _____

PERMISSION FOR TREATMENT

I hereby grant permission to the team physicians and those professional personnel designated by Poway Unified School District to treat my son or daughter in the event of any injury. In the event of a serious injury, if I am unable to give my consent at that time, this consent is to include any and all emergency procedures deemed necessary by the attending emergency personnel. I also understand that in the event of injury, every reasonable attempt will be made to contact me prior to securing medical treatment beyond basic first aid. Parent Initials _____ Student/Athlete Initials _____

PROOF OF INSURANCE

In compliance with California Education Code 32221, I certify that there is in effect at this time insurance coverage for medical expenses resulting from bodily injury of at least \$5,000 for my son or daughter, and that this coverage will remain in effect throughout the time that he or she participates in sports. I also give my permission for the above named student to participate in sports, including regularly scheduled trips by supervised school transportation.

NAME of Insurance Carrier _____ Policy/Group # _____ Parent Initials _____ Student/Athlete Initials _____

MEDIA/TRANSCRIPTS RELEASES

I understand that my name, picture, and/or GPA may be released to the media and transcripts to colleges. Parent Initials _____ Student/Athlete Initials _____

REFER TO ATHLETIC HANDBOOK FOR THIS SECTION LOCATED ON SCHOOL WEBSITE UNDER ATHLETICS

ATHLETIC HANDBOOK

I have reviewed and agree to abide by the guidelines/policies in the Athletic Handbook which is posted on school website. By signing below, I acknowledge that it is my responsibility to read and understand these rules and discuss them with my parent/guardian/athlete. Parent Initials _____ Student/Athlete Initials _____

CIF CONCUSSION INFORMATION

I agree that the safety of the athletes always come first. I have read the CIF Concussion Information Sheet and am familiar with the signs and symptoms of a concussion. I understand and support the decision that any athlete suspected of suffering a serious head injury may be removed from a game or practice immediately and will not be allowed to return to activity until medically cleared. Parent Initials _____ Student/Athlete Initials _____

ATHLETIC POLICY AGAINST HAZING

Poway Unified School District strives to maintain a healthy athletic program in which students feel safe, welcome and proud of the school and the athletic programs that they represent. I understand that hazing of any kind is not allowed on this campus and in the athletic program. This includes mental, verbal and physical acts. I further understand that it is my duty to report any acts of hazing that I see to a coach or administrator on campus. By signing below, I agree to uphold this District policy and understand that any violation will result in my immediate suspension from athletics and further disciplinary action as outlined in District policy and procedures. Parent Initials _____ Student/Athlete Initials _____

ETHICS IN SPORTS POLICY

I read and accept and understand the Policy Statement, Code of Ethics, The Pillars and Principles of Pursuing Victory with Honor, and the Violations, Minimum Penalties, and Appeal Process of the CIF- San Diego Section ETHICS IN SPORTS Policy. I agree to abide by this policy while participating and/or spectating at CIFSDS athletic events regardless of contest site or jurisdiction. Parent Initials _____ Student/Athlete Initials _____

SUDDEN CARDIAC ARREST

I agree that the safety of the athletes always come first. I have read the Sudden Cardiac Arrest information Sheet and am familiar with the signs and symptoms of SCA. I understand and support the decision that any athlete suspected of suffering sudden cardiac arrest may be removed from a game or practice immediately and will not be allowed to return to activity until medically cleared. Parent Initials _____ Student/Athlete Initials _____

I have read all of the above statements/documents & understand them fully. We agree/consent to their contents. **Both parents/guardians must sign below.**

Print Student/Athlete Name _____
X _____
Student/Athlete Signature

Print Parent/Guardian Name _____
X _____
Parent/Guardian Signature

Print Parent/Guardian Name _____
X _____
Parent/Guardian Signature



**CIF-SAN DIEGO SECTION
RESIDENCE & ELIGIBILITY VERIFICATION
Athletic/Extracurricular Participation**

** To be completed by individual with whom student resides**

Pursuing Victory with Honor

Student Name:	Grade:	Sport(s):
Address:	DOB:	Parent Cell #:
Home Phone #:	Age:	Parent Cell #:

1. I am the one with whom this student-athlete **resides**: (check one box)
- Parent Legal Guardian Relative Caretaker Foster Parent Emancipated Minor

2. I AFFIRM THAT THIS STUDENT RESIDES AT THE FOLLOWING ADDRESS:

Street Address

City/State/Zip

Telephone

PARENTS' ADDRESS (if different than listed in #2)

Mother's Street Address

City/State/Zip

Father's Street Address

City/State/Zip

3. Student Status: (check one box)
- Continuing Student Incoming 9th Grader New Resident Administrative Placement Intra-District Transfer Inter-District Transfer

4. **ALL School(s) Attended Last Year**

Name of School	Address	City/State/Zip	Sports(s) Played
_____	_____	_____	_____
_____	_____	_____	_____

5. I understand that this street address is within the High School boundaries and/or I have followed the District transfer procedures.
I also understand that falsifying this information will cause team forfeiture and immediate ineligibility.

Print Name of Person Checked on Line 1

X _____ **X** _____
Signature of Person with Whom Student/Athlete Date Student/Athlete Signature Date

**THIS SECTION IS TO BE COMPLETED BY ALL
NEW STUDENTS, INCOMING 9th GRADERS AND ALL TRANSFER STUDENTS**

State CIF Bylaws require that all information provided in regard to any aspect of student eligibility to participate in athletics must be true, correct, accurate, and complete. State CIF Bylaws also require that parents, students, coaches and schools must disclose any pre-enrollment contact of any kind whatsoever with the parent or student during the 24 months prior to enrollment in the school.

I understand that it is my responsibility to see the Athletic Director to receive the CIF San Diego Section Transfer Student Eligibility forms prior to athletic participation. Check one:

- There has been no pre-enrollment contact of any kind whatsoever during the previous 24 months with anyone at or associated with the school or its athletic programs.
- There has been pre-enrollment contact during the previous 24 months with individuals at or associated with the school and its athletic programs by: (check all that apply) Clubs Camps 8th Grade Parent Night Conversation with High School Coach.

A true, correct, and complete disclosure of that contact is written on the back or attached to this form.



PRE-PARTICIPATION PHYSICAL EVALUATION MEDICAL HISTORY

(This form is to be completed by the patient and parent prior to seeing the physician. Submit original to school Athletics Office. Physician should retain a copy.)

Mt. Carmel HS Del Norte HS Poway HS Rancho Bernardo HS Westview HS

Student Name:	Student ID #:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Sport(s):	Date of Birth:	Grade:	Age:

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking.

Do you have any allergies? Yes No If yes, please identify allergy Medicines Pollens Food Stinging Insects

GENERAL QUESTIONS	Yes	No	MEDICAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?			30. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
2. Do you have any ongoing medical conditions? If so please identify: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other:			31. Do you have groin pain or a painful bulge or hernia in the groin area?		
3. Have you ever spent the night in the hospital?			32. Have you had infectious mononucleosis (mono) within the last 3 months?		
4. Have you ever had surgery?			33. Do you have any rashes, pressure sores, or other skin problems?		
5. Do you have any physical or mental impairment which may affect your participation in athletics or may require accommodations?			34. Have you had a herpes or MRSA skin infection?		
HEART HEALTH QUESTIONS ABOUT YOU			35. Have you ever had a head injury or concussion?		
6. Have you ever passed out or nearly passed out DURING or AFTER exercise?			36. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
7. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			37. Do you have a history of seizure disorder?		
8. Does your heart ever race or skip beats (irregular beats) during exercise?			38. Do you have headaches with exercise?		
9. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> Kawasaki disease <input type="checkbox"/> A heart murmur <input type="checkbox"/> A heart infection Other:			39. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
10. Has a doctor ever ordered a test for your heart? ECG/EKG, echocardiogram?			40. Have you ever been unable to move your arms or legs after being hit or falling?		
11. Do you get lightheaded or feel short of breath during exercise?			41. Have you ever become ill while exercising in the heat?		
12. Have you ever had an unexplained seizure?			42. Do you get frequent muscle cramps when exercising?		
13. Do you get more tired or short of breath more quickly than your friends during exercise?			43. Do you or someone in your family have sickle cell trait or disease?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY			44. Have you had any problems with your eyes or vision?		
14. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)?			45. Have you had any eye injuries?		
15. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?			46. Do you wear glasses or contact lenses?		
16. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			47. Do you wear protective eyewear, such as goggles or a face shield?		
17. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			48. Do you worry about your weight?		
BONE AND JOINT QUESTIONS			49. Are you trying to or has anyone recommended that you gain or lose weight?		
18. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			50. Are you on a special diet or do you avoid certain types of foods?		
19. Have you ever had broken or fractured bones or dislocated joints?			51. Have you ever had an eating disorder?		
20. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?			52. Do you have any concerns that you would like to discuss with a doctor?		
21. Have you ever had a stress fracture?			FEMALES ONLY		
22. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)			53. Have you ever had a menstrual period?		
23. Do you regularly use a brace, orthotics, or other assistive device?			54. How old were you when you had your first menstrual period?		
24. Do you have a bone, muscle, or joint injury that bothers you?			55. How many periods have you had in the last 12 months?		
25. Do any of your joints become painful, swollen, feel warm, or look red?			EXPLAIN "YES" answers here with dates and details: (Attachment ok if necessary)		
26. Do you have any history of juvenile arthritis or connective tissue disease?			_____		
27. Do you cough, wheeze, or have difficulty breathing during or after exercise?			_____		
28. Have you ever used an inhaler or taken asthma medicine?			_____		
29. Is there anyone in your family who has asthma?			_____		

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

Student/Athlete Signature _____ Date _____

 Parent/Guardian Signature _____ Date _____

**PRE-PARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION FORM**

(This form is to be completed by the physician. Submit original to school Athletics Office. Physician should retain a copy.)

Student Name:	Date of Birth:	Age:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
EXAMINATION				
Height:	Weight:	BMI:	BP: /	Pulse:
		Vision: R 20/		L 20/ Corrected <input type="checkbox"/> Yes <input type="checkbox"/> No

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyper		
Eyes/Ears/Nose/Throat • Pupils Equal • Hearing		
Lymph Nodes		
Heart • Murmurs (auscultation standing, supine, +/- Valsalva • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic		
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder/arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		
Functional • Duck-walk, single leg hop		

- CLEARED for all sports WITHOUT restriction.**
- Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____
- NOT CLEARED:** Pending further evaluation For any sports For certain sport _____
- REASON:** _____
- Recommendations _____

(Student's name) _____ was examined by me on (date) / / for a pre-participation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is 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 clearance until the problem is resolved and the potential consequences are completely explained to the athlete and parents/guardians.

Print Physician's Name: _____ Phone Number: _____

Physician's Signature: **X** _____ **Physician's Office Stamp HERE** →





**POWAY UNIFIED SCHOOL DISTRICT
MEDICAL INFORMATION RELEASE FORM FOR CO-CURRICULAR ACTIVITY**

This form is provided to the coach and will be taken with the team wherever they travel. Please fill it out completely and be specific.
The form gives parental consent for any staff/chaperone approved by the school principal to secure emergency services (medical, dental, paramedic, ambulance) for the student at the parent/guardian expense. Efforts will be made to contact the parent/guardian prior to treatment or hospitalization.
An authorization with a physician's signature must be attached if the athlete takes any prescription medication.

Student Name:	Sport(s):	
Parent/Guardian Name:	Graduating Year:	
Address:	City/ZIP	
Home Phone:	Mother Cell:	Mother Work:
	Father Cell:	Father Work:

IN CASE OF EMERGENCY, A REPRESENTATIVE OF THE PUSD ATHLETIC DEPARTMENT HAS THE AUTHORITY TO SECURE MEDICAL OR SURGICAL TREATMENT AND TRANSPORT AS NECESSARY. EVERY ATTEMPT WILL BE MADE TO CONTACT THE EMERGENCY PERSONS LISTED BELOW.

Family Doctor:	Dr. Phone #:
Emergency Person to Contact:	Phone #:
Relationship to Student:	
Emergency Person to Contact:	Phone #:
Relationship to Student:	

List all information helpful to a physician in case of emergency including information which school staff and chaperones need to be aware of regarding the student's safety. Updated information shall be provided by the parent/guardian.

MEDICAL PROBLEMS: (diabetes, asthma, seizures)	TREATMENT:
ALLERGIES: (food, bee stings, medication)	TREATMENT:

SCHOOL RULES ARE IN EFFECT FOR ALL SCHOOL SPONSORED ACTIVITIES

MEDICATION: Prescription and non-prescription medications are permitted only with a written statement from the physician and parent/guardian indicating desire that the District assist the student as set forth by the physician. If prescription or non-prescription medication is necessary, an AUTHORIZATION FOR MEDICATION ADMINISTRATION must be attached. I understand that staff/chaperones may assist my student in taking the medicine(s) as directed by my physician. I will provide the medicine(s) in the prescription container(s) labeled with the name of my student, the prescribing physician's name, and the time and dosage of medication prescribed. I agree to hold harmless and indemnify the Poway Unified School District, its officers, employees, agents or chaperones from and against any and all liability, loss, expense or claims for illness, injury or damage any student may incur from medication assistance.

I UNDERSTAND THAT BY SIGNING THIS FORM:

1. I give permission for my son or daughter to participate in Poway Unified School District athletics.
2. I give permission for staff/chaperones to provide first aid care and secure emergency care at my expense if needed.
3. I release the Poway Unified School District, its officers, employees, agents and its chaperones from any and all liability, loss, expense or claim for illness, injury or damages that may arise from participation in the athletics program or any associated activity. Further, I understand that the District does not provide accident/medical insurance for students and that I am expected to provide such insurance coverage.
4. I am aware that injuries may occur to the athlete while participating in interscholastic athletics. I have been advised of this danger.

Name of Insurance Company

Insurance Policy/Group Number

X _____
Parent/Guardian Signature

Date

X _____
Parent/Guardian Signature

Date

BOTH PARENTS/GUARDIANS MUST SIGN ABOVE