THURGOOD MARSHALL ACADEMY PCHS

ATHLETIC INFORMATION PACKET

SY 2015-2016

THE INFORMATION CONTAINED IN THIS PACKET MUST BECOMPLETED BY BOTH THE STUDENT ATHLETE AND PARENT/GUARDIAN AND RETURNED TO MRS. THOMPSON, ATHLETIC DIRECTOR.

*****BEFORE ANY STUDENT CAN PARTICIPATE IN ANY ATHLETIC PROGRAM, HE/SHE MUST HAVE A CURRENT (YEARLY) PHYSICAL EXAM WITH CLEARANCE FORM ON FILE AT THURGOOD MARSHALL ACADEMY.**** Physical forms attached in this packet.**

Please contact Mrs. Thompson with any questions or concerns.
202-210-0845

CHECK LIST:

Eligibility Requirements Signed ☐

Medical Waiver Signed ☐

Parental Permission Form Signed ☐

Health Assessment Form Signed ☐

Physical Form Signed by Doctor ☐

Thurgood Marshall Academy Department of Athletics

CONSENT FOR ATHLETIC PARTICIPATION

Student Name:____**Grade:** ________

Sport(s) student is interested in playing this school year ____

DATE OF BIRTH:____________________ ***AGE ON JULY 1ST***______ ***SCHOOL YEAR*** ___________

ADDRESS:____

HOME PHONE:____________________________ ***OTHER PHONE #***____________________________

STUDENT PARTICIPATION PERMISSION

Participation in competitive athletics may result in severe injury, including paralysis, or death. Improvement in equipment, medical treatment and physical conditioning, as well as rule changes, have reduced these risks, but it impossible to totally eliminate such occurrences from athletics.

I hereby give my consent for the above named student to represent Thurgood Marshall Academy in ALL SPORT programs offered. This includes preseason tryouts and practices, in season and post season play. This includes travel for local and out of town trips.

With the exception of: ____

Statement: Prior to the interscholastic programs and/or trips, all parents/guardians of student athletes and the student athlete are required to sign this form and are deemed to have waived all claims against Thurgood Marshall Academy, its employees, or representatives for any injury, accident, or illness occurring during or by reason of participation in an interscholastic athletic program or trip. I accept the responsibility to inform the school of any future change of this information. Students participating in athletic competitions may be photographed during the competition.

I, the parent or guardian of the minor applicant, hereby agree that Thurgood Marshall Academy, or its representative, may video tape, photograph and voice record the herein minor applicant for media, marketing, or promotional purposes related to his/her participation in Thurgood Marshall Academy's Athletic Program. This may include posting on line, photo displays and other promotional opportunities.

I have read this form and understand the rules contained herein, and the information supplied is true and correct to the best of my knowledge.

____ ________________________

Parent/Guardian Signature **DATE**

____________________________ ________________ ________________

Relationship to Student **Home/Work Phone** **Cell Phone #**

THURGOOD MARSHALL ACADEMY PUBLIC CHARTER HIGH SCHOOL

2427 MARTIN LUTHER KING, JR AVE., SE
WASHINGTON, D.C. 20020

PHONE: (202) 563-6862
FACSIMILE: (202) 563-6946

Parent/Guardian Consent for tryouts and games
TMA Athletics

Waiver of Claims and Medical Authorization

My child, ____, has my permission to participate in the Athletics Program at Thurgood Marshall Academy. He/She has my permission to travel with the coaches to away competitions. Students will travel to competitions, the dates and locations of which will be announced later in the season via chartered bus.

I agree to direct my child to cooperate and conform to directions and instructions from TMA personnel and representatives in charge of the event. Should it be necessary for my child to have medical treatment, I hereby give TMA personnel and representatives permission to use their judgment in obtaining medical services, and I give permission to the physician selected to render medical treatment deemed necessary and appropriate by the physician. I understand that TMA has no insurance covering such medical or hospital costs incurred, and, therefore, any cost incurred for such treatment shall be my sole responsibility.

Insurance is not needed for participation in the practices, but please check all that apply:

☐ I am covered by accident/medical insurance
☐ My child is covered by accident/medical insurance.
☐ My child is not covered by accident/medical insurance.

If insured, what is the name and type of insurance?____
Are there any allergies or medical conditions of which we should be aware? ______________________

Students will be traveling by: Chartered bus. The cost of transportation for each student will be provided by Thurgood Marshall Academy. All persons attending the practices are deemed to have waived all claims against TMA and its employees and representatives for injury, accident, illness or death occurring during or by reason of the practices.

I have read and understand the foregoing statement and agree to assume the responsibility stated and waive all claims against Thurgood Marshall Academy, its personnel and representatives.

The Athletics program is under the supervision of Michele Thompson, Athletic Director, 202-210-0845.

______________________	______________________	____________
Signature of Parent/Guardian	Printed Name	Date
Street Address	City/State	Zip Code

Home Phone Number____________________

Cell Phone Number ____________________

Work Phone Number____________________

Emergency Phone Number____________________

Thurgood Marshall Academy

Parental and Student Release Acceptance of Risk

I understand that the risk of injury, including serious injury, is inherent in any athletic event, including games or practice. I accept this risk.

I agree to release Thurgood Marshall Academy (TMA), members of its staff and any person acting in its behalf from responsibility for any accident or injury to my son/daughter/ward resulting from participation in a sports event or from going to or from a sports event, including out of town events.

I understand that TMA's insurance plan provides only limits supplemental medical coverage and compensation for injuries. Therefore, TMA's medical policy may not be sufficient to cover the difference between the cost of medical care and treatment my son/daughter/ward receives allowing an injury and the compensation provided by the policy providing primary coverage.

I have reviewed my family medical policy to assure that it adequately covers any injury that may arise from any sport my son/daughter/ward plays at TMA. I agree that I am responsible for medical expenses that may occur from participation in sports by my son/daughter/ward.

If in the judgment of any TMA faculty member, administrator, or coach my son/daughter/ward needs immediate medical care and treatment as a result of a serious injury, I request and consent to such care and treatment by any physician, trainer, nurse, hospital, or school or league representative.

I understand that, in the event of serious injury, every attempt will be made to contact me immediately. If I cannot be contacted, please administer any necessary treatment to my son/daughter/ward.

I give my permission for TMA personnel to administer over the counter medication to my son/daughter/ward in the event of a non-serious injury in order to alleviate pain or discomfort.

Do not administer the following medicine or drug because they could be harmful to my son/daughter/ward. (If none, please state none.)

____

Parent/guardian signature ________________________________ Date ____________

I understand that sports are potentially dangerous and agree to accept the risk of injury associated with my participation in a sport.

Player signature ________________________________ Date ____________

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

Part 1: Child's Personal Information **Parent/Guardian:** ***Please complete Part 1 clearly and completely & sign Part 5 below.***

Child's Last Name:	*Child's First & Middle Name:*	*Date of Birth:*	*Gender:* ☐ M ☐ F	*Race/Ethnicity:* ☐ White Non Hispanic ☐ Black Non Hispanic ☐ Hispanic ☐ Asian or Pacific Islander ☐ Other_____________
Parent or Guardian Name:	*Telephone:* ☐ Home ☐ Cell ☐ Work	*Home Address:*		*Ward:*
Emergency Contact Person:	*Emergency Number:* ☐ Home ☐ Cell ☐ Work	*City/State (if other than D.C.)*		*Zip code:*
School or Child Care Facility:	☐ Medicaid ☐ Private Insurance ☐ None ☐ Other ______________________________		*Primary Care Provider (PCP):*	

Part 2: Child's Health History, Examination & Recommendations **Health Provider: Form must be fully completed.**

DATE OF HEALTH EXAM:	WT ☐ LBS ☐ KG	HT ☐ IN ☐ CM	BP: ______ (>3 yrs) ☐ NML ☐ABNL	Body Mass Index (>2 yrs) (BMI)___________ %______________
HGB / HCT *(Required for Head Start)*	Vision Screening ☐ Glasses ☐ Referred Right 20/____ Left 20/____		Hearing Screening Pass________ Fail_________ ☐ Referred	

HEALTH CONCERNS:			REFERRED or TREATED	HEALTH CONCERNS:			REFERRED or TREATED
Asthma	☐ NO	☐ YES	☐ Referred ☐ Under Rx	Language/Speech	☐ NONE	☐ YES	☐ Referred ☐ Under Rx
Seizure	☐ NO	☐ YES	☐ Referred ☐ Under Rx	Development/ Behavioral	☐ NONE	☐ YES	☐ Referred ☐ Under Rx
Diabetes	☐ NO	☐ YES	☐ Referred ☐ Under Rx	Other____________	☐ NONE	☐ YES	☐ Referred ☐ Under Rx

ANNUAL DENTIST VISIT: (Age 3 and older): Has the child seen a Dentist/Dental Provider within the last year? ☐ YES ☐ NO ☐ Referred

A. Significant health history, conditions, communicable illness, or restrictions that may affect school, child care, sports, or camp.
☐ NONE ☐ YES, please detail:

____

____

B. Significant food/medication/environmental allergies that may require *emergency medical care* at school, child care, camp, or sports activity.
☐ NONE ☐ YES, please detail: ____

____

C. Long-term medications, over-the-counter-drugs (OTC) or special care requirements.
☐ NONE ☐ YES, please detail (For any medications or treatment required during school hours, a Physician's Medication Authorization Order should be submitted with this form)

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____

____

Part 3: Tuberculosis & Lead Exposure Risk Assessment & Testing:

TB RISK ASSESSMENTS	☐ HIGH→ ☐ LOW	Tuberculin Skin Test (TST) DATE:	☐ NEGATIVE ☐ POSITIVE	If **TST** Positive ☐ CXR NEGATIVE ☐ CXR POSITIVE ☐ TREATED	**Health Provider:** POSITIVE TST should be referred to PCP for evaluation. For questions, call T.B. Control: 202-698-4040
LEAD EXPOSURE RISKS	☐ YES→ ☐ NO	LEAD TEST DATE:	RESULT:	**Health Provider:** *ALL* lead levels must be reported to DC Childhood Lead Poisoning Prevention Program: Fax: 202-481-3770	

Part 4: Required Provider Certification and Signature

☐ YES ☐ NO This child has been appropriately examined & health history reviewed. At time of exam, this child is in satisfactory health to participate in all school, camp or child care activities except as noted above.

☐ YES ☐ NO This athlete is cleared for competitive sports.

☐ YES ☐ NO Age-appropriate health screening requirements performed within current year. If no, please explain:

____

____

Print Name	MD/NP Signature		Date
Address		Phone	Fax

Part 5: Required Parental/Guardian Signatures. (Release of Health Information)

I give permission to the signing health examiner/facility to share the health information on this form with my child's school, child care, camp, or appropriate DC Government Agency.

Print Name **Signature** **Date**

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

Student's Name: ____________________________/_________________________/________________ Date of Birth:_____/_____/________
Last First Middle Mo. /Day/ Yr.

Sex: ☐ Male ☐ Female School or Child Care Facility:____

Section 1: Immunization: Please fill in or attach equivalent copy with provider signature and date.

IMMUNIZATIONS	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN						
Diphtheria,Tetanus, Pertussis (DTP,DTaP)	1	2	3	4	5		
DT (<7 yrs.)/ Td (>7 yrs.)	1	2	3	4	5		
Tdap Booster	1						
Haemophilus influenza Type b (Hib)	1	2	3	4			
Hepatitis B (HepB)	1	2	3	4			
Polio (IPV, OPV)	1	2	3	4			
Measles, Mumps, Rubella (MMR)	1	2					
Measles	1	2					
Mumps	1	2					
Rubella	1	2					
Varicella	1	2	Chicken Pox Disease History: Yes ☐ When: Month____________ Year___________ Verified by:____ (Health Care Provider) Name & Title				
Pneumococcal Conjugate	1	2	3	4			
Hepatitis A (HepA) (Born on or after 01/01/2005)	1	2					
Meningococcal Vaccine	1						
Human Papillomavirus (HPV)	1	2	3				
Influenza (Recommended)	1	2	3	4	5	6	7
Rotavirus (Recommended)	1	2	3				
Other							

____ ___________________________________ __________
Signature of Medical Provider Print Name or Stamp Date

Section 2: MEDICAL EXEMPTION. For Health Care Provider Use Only.

I certify that the above student has a valid medical contraindication to being immunized at the time against: (check all that apply)

Diphtheria: (__) Tetanus: (__) Pertussis: (__) Hib: (__) HepB: (__) Polio: (__) Measles: (__) Mumps: (__) Rubella: (__) Varicella: (__) Pneumococcal: (__)

HepA: (__) Meningococcal: (__) HPV: (__)

Reason:____

This is a permanent condition (___) or temporary condition (___) until ____/____/____.

____ ___________________________________ __________
Signature of Medical Provider Print Name or Stamp Date

Section 3: Alternative Proof of Immunity. To be completed by Health Care Provider or Health Official.

I certify that the student named above has laboratory evidence of immunity: (Check all that apply & attach a copy of titer results)

Diphtheria: (__) Tetanus: (__) Pertussis: (__) Hib: (__) HepB: (__) Polio: (__) Measles: (__) Mumps: (__) Rubella: (__) Varicella: (__) Pneumococcal: (__)

HepA: (__) Meningococcal: (__) HPV: (__)

____ ___________________________________ __________
Signature of Medical Provider Print Name or Stamp Date