Revised 6/2019

PRE-PARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION FORM – VALID FOR 2 YEARS

Name:	Date of Birth:

Physician 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, 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 (Questions 4-13 of History Form).

EXAMINATION

Height:	Weight:	
BP: / (/)	Pulse:	Vision: R 20/ L 20/ Corrected: ☐ Yes ☐ No

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), echocardiogram, referral to cardiology for abnormal cardiac history or examination findings, or a combination of those.

☐ **Cleared for all sports without restriction for two (2) years.**

☐ Cleared for all sports without restriction for two (2) years with recommendation for further evaluation or treatment for:

☐ Cleared for all sports without restriction for less than two (2) years. Specify reasons and duration of approval below:

☐ Not Cleared

☐ Pending further evaluation ☐ For any sports ☐ For certain sports (please list):

Reason:

Recommendations/Comments:

I have examined the above-named student and completed the 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).

Name of healthcare professional (type/print):	Date of Issue:
Address:	Phone:
Signature of healthcare professional (MD/DO/ARNP/PA/Chiropractor):	

This physical is valid for a 2-year period unless otherwise noted by the physician in the "Recommendations" field listed above.

MEDICAL HISTORY

Note: Complete and sign this form (with your parents if younger than 18) before your appointment. The physician should keep a copy of this form in the chart for their records.

Note: An injury or medical condition results in a separate medical release.

Name:	Date of Birth:
Date of examination:	
Sex assigned at birth (F, M or intersex):	How do you identify your gender? (F, M or other):

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 of your allergies (i.e., 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.

MSHSAA PRE-PARTICIPATION DOCUMENTATION – ANNUAL REQUIREMENTS

INTERIM MEDICAL HISTORY

Note: Complete and sign this form (with your parents if younger than 18).
Note: An injury or medical condition results in a separate medical release.

Name:	Date of Birth:
Date:	
Sex assigned at birth (F, M or intersex):	How do you identify your gender? (F, M or other):
List past and current medical conditions:	
Have you had surgery since your last Pre-Participation Physical Examination (physical)? If yes, list those 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 of your allergies (i.e., medicines, pollens, food, stinging insects):	
Have you been diagnosed with any medical or health condition since your last PPE (physical)? If yes, please describe:	

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(s) or Guardian:
Date:

PARENT PERMISSION (Authorization for Treatment, Release of Medical Information, and Insurance Information)

Informed Consent: By its nature, participation in interscholastic athletics includes risk of serious bodily injury and transmission of infectious disease such as HIV and Hepatitis B. Although serious injuries are not common and the risk of HIV transmission is almost nonexistent in supervised school athletic programs, it is impossible to eliminate all risk. Participants must obey all safety rules, report all physical and hygiene problems to their coaches, follow a proper conditioning program, and inspect their own equipment daily. **PARENTS, GUARDIANS, OR STUDENTS WHO MAY NOT WISH TO ACCEPT RISK DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS FORM. STUDENTS MAY NOT PARTICIPATE IN MSHSAA-SPONSORED SPORT WITHOUT THE STUDENT'S AND PARENT'S/GUARDIAN/S SIGNATURE.**

I understand that in the case of injury or illness requiring transportation to a health care facility, a reasonable attempt will be made to contact the parent or guardian in the case of the student-athlete being a minor, but that, if necessary, the student-athlete will be transported via ambulance to the nearest hospital.

We hereby give our consent for the above student to represent his/her school in interscholastic athletics. We also give our consent for him/her to accompany the team on trips and will not hold the school responsible in case of accident or injury whether it be en route to or from another school or during practice or an interscholastic contest; and we hereby agree to hold the school district of which this school is a part and the MSHSAA, their employees, agents, representatives, coaches, and volunteers harmless from any and all liability, actions, causes of action, debts, claims, or demands of every kind and nature whatsoever which may arise by or in connection with participation by my child/ward in any activities related to the interscholastic program of his/her school.

In the event of an emergency or when the Parent(s) or Guardian is unable to directly supervise health care services needed by the student for injuries or illnesses sustained at any athletic practice, conditioning exercise or contest, I also give my consent to the rendering of necessary health care services for the student by a qualified provider (QP) covering the athletic practice, conditioning exercise or contest, including an athletic trainer, physician, physician assistant, nurse practitioner or other medically-trained professional licensed by the State of Missouri (or the state in which the student injury or illness occurs) and who is acting in accordance with the scope of practice under their designated state license and any other requirement imposed by state law. In emergency situations, the QP may also be a certified paramedic or emergency medical technician for the purpose of providing emergency health care and transport. Health care services are defined as services including, but not limited to, evaluation, diagnosis, first aid, emergency care, stabilization, treatment and referral. I further authorize the QP who provides such health care services to disclose such information about the student's injury or illness, diagnosis, care and treatment in the professional judgment of the QP to the student's athletic director, coaches, school nurse and any classroom teacher required to provide academic accommodation to assure the student's recovery and safe return to activity. If the Parent(s) or Guardian believes that the student is in need of further evaluation, treatment, rehabilitation or health care services for the injury or illness, the student may be treated by the physician or provider of his or her choice.

To enable the MSHSAA to determine whether the herein named student is eligible to participate in interscholastic athletics in the MSHSAA member school, I consent to the release of any and all portions of school record files to MSHSAA, beginning with seventh grade, of the herein named student, specifically including, without limiting the generality of the foregoing, birth and age records, name and residence address of parent(s) or guardian(s), residence address of the student, academic work completed, grades received, and attendance data.

We confirm that this application for the above student to represent his/her school in interscholastic athletics is made with the understanding that we have studied and understand the eligibility standards that our son/daughter must meet to represent his/her school and that he/she has not violated any of them. We also understand that if our son/daughter does not meet the citizenship standards set by the school or if he/she is ejected from an interscholastic contest because of an unsportsmanlike act, it could result in him/her not being allowed to participate in the next contest or suspension from the team either temporarily or permanently.

I consent to the MSHSAA's use of the herein named student's name, likeness, and athletic-related information in reports of contests, promotional literature of the Association and other materials and releases related to interscholastic athletics.

We further state that we have completed that part of this certificate which requires us to list all previous injuries or additional conditions that are known to us which may affect this athlete's performance or treatment and we certify that it is correct and complete.

The MSHSAA By-Laws provide that a student shall not be permitted to practice or compete for a school until it has verification that he/she has basic health/accident insurance coverage, which includes athletics. Our son/daughter is covered by basic health/accident insurance for the current school year as indicated below:

Name of Insurance Company:	Policy Number:
Signature of Parent(s) or Guardian:	Date:
Has this student incurred a medical condition since their last physical examination?	☐ Yes ☐ No

STUDENT AGREEMENT (Regarding Conditions for Participation)

This application to represent my school in interscholastic athletics is entirely voluntary on my part and is made with the understanding that I have studied and understand the eligibility standards that I must meet to represent my school and that I have not violated any of them.

I have read, understand, and acknowledge receipt of the MSHSAA brochure entitled "How to Maintain and Protect Your High School Eligibility," which contains a summary of the eligibility rules of the MSHSAA. (I understand that a copy of the *MSHSAA Handbook* is on file with the principal and athletic administrator and that I may review it in its entirety, if I so choose. All MSHSAA by-laws and regulations from the *Handbook* are also posted on the MSHSAA website at www.mshsaa.org).

I understand that a MSHSAA member school must adhere to all rules and regulations that pertain to school-sponsored, interscholastic athletics programs, and I acknowledge that local rules may be more stringent than MSHSAA rules.

I also understand that if I do not meet the citizenship standards set by the school or if I am ejected from an interscholastic contest because of an unsportsmanlike act, it could result in me not being allowed to participate in the next contest or suspension from the team either temporarily or permanently.

I understand that if I drop a class, take course work through Post -Secondary Enrollment Option, Credit Flexibility, or other educational options, this action could affect compliance with MSHSAA academic standards and my eligibility.

I understand that participation in interscholastic athletics is a privilege and not a right. As a student athlete, I understand and accept the following responsibilities:

- I will respect the rights and beliefs of others and will treat others with courtesy and consideration.
- I will be fully responsible for my own actions and the consequences of my actions.
- I will respect the property of others.
- I will respect and obey the rules of my school and laws of my community, state, and country.
- I will show respect to those who are responsible for enforcing the rules of my school and the laws of my community, state, and country.

I have completed and/or verified that part of this certificate which requires me to list all previous injuries or additional conditions that are known to me which may affect my performance in so representing my school, and I verify that it is correct and complete.

Signature of Athlete:	Date:
Have you experienced a medical condition since your last physical examination?	☐ Yes ☐ No

PARENT AND STUDENT SIGNATURE (Concussion Materials)

I accept responsibility for reporting all injuries and illnesses to my school and medical staff (athletic trainer/team physician) including any signs and symptoms of a CONCUSSION. I have received and read the MSHSAA materials on Concussions, which includes information on the definition of a concussion, symptoms of a concussion, what to do if I have a concussion and how to prevent a concussion. I will inform my school and athletic trainer/team physician immediately if I experience any of these symptoms or if I witness a teammate with these symptoms.

Signature of Athlete:	Date:
Signature of Parent(s) or Guardian:	Date:

EMERGENCY CONTACT INFORMATION

Parent(s) or Guardian	Address	Phone Number
Name of Contact	Relationship to Athlete	Phone Number
Name of Contact	Relationship to Athlete	Phone Number

School Health Services - Health Card

Grade:_____
SY: 2020/21

Student Name:_____ DOB:_____
Parent/Guard 1:_____ Ph#:_____ Alt#:_____
Parent/Guard 2:_____ Ph#:_____ Alt#:_____

Does your child have:
Allergies? ___No ___Yes** if yes, please specify allergen, reaction, and treatment:_____
_____
Is a special diet required at school? ___No ___Yes** (Please provide Doctor Documentation of restriction.)
What is the substitution or restriction required?_____
Has this required emergency action in the past? ___No ___Yes** →
Describe:_____
Is emergency medication required? ___No ___Yes** List:_____

Does your child have a life-threatening condition? ___No ___Yes** →
Describe:_____
_____(Please provide any available medical action plan for your child's condition).

Asthma? ___No ___Yes** Diagnosed by a doctor? ___No ___Yes** Inhaler at school? ___No ___Yes** Symptoms are triggered by:_____
Treatment:_____

Diabetes? ___No ___Yes** → Does your child take insulin? ___No ___Yes
Uses: ___Pump ___Pen ___Syringes Daily snacks? ___No ___Yes**
Will he/she be doing daily testing at school? ___No ___Yes**

Seizure Disorder? ___No ___Yes** Describe seizures:_____
Date of last seizure:_____ Medication/treatment:_____

Heart Condition? ___No ___Yes** Describe:_____
Any physical restrictions? ___No ___Yes** Describe:_____

Other Medical conditions: ___No ___Yes** Describe:_____

Please complete the following regarding PHYSICIAN DIAGNOSED health concerns that pertain to your child:
Does your child have any physical or mental impairments that the District should be aware?
___No ___Yes
If yes, please describe:_____

Such impairments may include, but are not limited to, the following. Please check those that apply:

___ADD ___ADHD ___Autism Spectrum Disorder ___Depression ___Bipolar ___OCD

___Other: _____

Does your child have a condition that prevents or limits PE participation? ___No ___Yes

-->**Dr's note required.** If yes, please describe:

_____

Does your child require Specialized Health Care Procedures at school? ___No ___Yes** → If yes, please explain:

_____

Does your child take any medication? ___No ___Yes → If yes, please list:

Med/dose _____ times/day_____school dose time_____

Med/dose _____ times/day_____school dose time_____

Med/dose _____ times/day_____school dose time_____

Medical: Does student have medical insurance?___Yes ___No

Preferred Hospital:_____

Dental: Does your child have dental coverage?___Yes ___No

Vision/Hearing: Has student had a professional exam in the past 12 months? ___Yes ___No

Does your child wear glasses or contacts? ___Yes ___No

Does your child wear hearing aids? ___Yes ___No

OVER THE COUNTER MEDICATION PERMISSION

At the discretion of the school nurse or his/her designee, I give permission for the following medications to be given in recommended doses to my child as needed (please check each medication):

Acetaminophen/Tylenol	Yes_____	No_____
Ibuprofen/Motrin/Advil	Yes_____	No_____
Antacid/TUMS	Yes_____	No_____
Benadryl/Diphenhydramine	Yes_____	No_____
Orajel	Yes_____	No_____
Hydrocortisone 1% cream	Yes_____	No_____
Triple Antibiotic Ointment	Yes_____	No_____

My signature below verifies the above information to be accurate to the best of my knowledge. I authorize health information to be shared between my child's health care providers and the school health services staff as needed. I understand the information given above will be shared with the appropriate school staff for my child's health and safety at school and at school associated events. If either I or an authorized emergency contact person cannot be reached at the time of a medical emergency, I authorize and direct school staff to send my child to the most easily accessible hospital or physician. I understand that I will assume full responsibility of any transport or emergency medical services rendered.

Parent/guardian signature_____

Acknowledgement Concerning Student Handbooks

I have read and understood the Orrick High School Student Handbook that contains a copy of the district's discipline policy. I understand that I can access both on the district website and/or the Orrick High School App. If a hard copy is needed I may request a copy of it in the High School Office.

_____	_____
Student signature	Date
_____	_____
Parent signature	Date

Acknowledgement Concerning Use of Student Lockers

I acknowledge and understand that:

1. Student lockers are the property of the Orrick R-XI School District.
2. Student lockers remain at all times under the control of the School District.
3. I am expected to assume full responsibility for my locker.
4. The School District retains the right to inspect student lockers for any reason, at any time, without notice, without student consent and without a search warrant.
5. This will remain in effect for the duration of the student's enrollment within the Orrick R-XI School District.

_____	_____	_____
Student signature	Date	Locker #

Acknowledgement Concerning Use of Parking Lots

I acknowledge and understand that:

1. Students are permitted to park on school premises as a matter of privilege, not right.
2. The School District retains the authority to conduct routine patrols of student parking lots and inspections of the exteriors of student automobiles on school property.
3. The School District may inspect the interiors of student automobiles whenever a school authority has reasonable suspicion to believe illegal or unauthorized materials are contained inside the automobiles.
4. Such patrols and inspections may be conducted without notice, without student consent and without a search warrant.
5. If I fail to provide access to the interior of my automobile, upon the request of the school official, I will be subject to school disciplinary action.
6. This will remain in effect for the duration of the student's enrollment within the Orrick R-XI School District.

_____ _____

Student signature Date

Parent Permission Form

School districts throughout Missouri have been asked to participate in the drug-free survey every other year since 1991. With the inclusion of a violence component in 1995, the instrument became the Safe and Drug-Free Schools and Communities (SDFSC) Survey. The survey is administered to students in grade 9 and two optional levels selected grades from sixth grade through twelfth grade.

The results of the survey are used to assist the school district in evaluation and planning of its comprehensive school health program. Specifically, the results of the survey indicate the extent of alcohol, marijuana, and other drug use as well as incidences of violence experienced by students.

During the past 12 months, how many times were you in a physical fight?

During the past 30 days, on how many days did you smoke cigarettes?

Students are not asked to identify themselves on the survey form. No individual student responses are reported or maintained.

Student participation in the survey assists your school district in gathering local data regarding the extent of alcohol, tobacco, and other drug use and violence. This will then also assist in determining statewide levels of such use, safety issues, and incidences of violence.

Student's name _____ Grade ____

My child has permission to participate in the Safe and Drug-Free Schools and Communities Survey.

Parent's signature _____

Telephone number _____ Date _____

Transportation Request Form
Orrick School District

Grade:_____

Student Name (last name first): _____

Home Address: _____ City: _____

Zip: _____ Contact Phone 1. _____ 2._____

Mother's Name: _____ Father's Name: _____

Work phone: _____ Work Phone: _____

( ) My child will require transportation from home address.

( ) My child will not require transportation to/from school.

COMPLETE THE FOLLOWING IF THE STUDENT'S PICKUP AND/OR DROP OFF ADDRESS ARE DIFFERENT FROM THE HOME ADDRESS.

PICKUP ADDRESS: circle days: M T W TH F ALL

DROP OFF ADDRESS: circle days: M T W TH F ALL

FOR BUS BARN USE ONLY: Bus #: _____ **Bus Stop:** _____

P/U Time: _____ AM (Be at the stop 5 min. prior) **Appr. D/O Time:** _____ PM

I have read and understand the expectations for the bus and the bus stop. **Initials** :_____

EXPECTATIONS FOR STUDENT TRANSPORTATION

On The Bus

1. Immediately follow the directions of the driver.
2. Sit in your seat (not on knees or backpack) facing forward while the bus is moving.
3. Talk quietly, no foul language or gestures.
4. Keep all parts of your body inside the bus at all times.
5. Keep arms, legs and belongings to yourself.
6. No fighting, harassment, intimidation or inappropriate conduct.
7. Do not throw any objects (balls and toys must remain in backpacks).
8. No eating, drinking or possession/use of tobacco or drugs.
9. Do not bring any weapons or dangerous objects on the school bus.

At The Bus Stop

1. Get to your stop five minutes before the scheduled pickup time. The bus driver will not wait for late students.
2. Stay away from the street, road or highway when waiting for the bus.
3. Wait till the bus stops before approaching.
4. If you can't see the driver's eyes, they cannot see you.
5. After getting off the bus, move away from the bus
6. If you must cross the street, always cross in front of the bus once the driver has signaled that it is clear with a thumbs up.
7. Preschool and Kindergartners must have a parent or authorized individual at the bus stop.

Elementary & High School

iPad Insurance Policy

Who: All students receiving a district-owned iPad must purchase an insurance policy before an iPad will be issued.

What: Policy A - $35 with no deductible on a claim without negligence

Policy B - $20 with a $25 deductible on a claim without negligence

*10% off for 3 students in family; 15% off for 4; 20% for 5 or more.

Both policies cover accidental damage, cracked screens, liquid submersion, fire, flood, natural disasters, power surge by lightning, and theft without negligence. Claims of these nature must be made within 5 school days of the occurrence by submitting a claim form found on the district web-site. In case of theft or other criminal acts, a police report MUST be filed by the student or parent within 72 hours of the occurrence. Incidents happening off campus must be reported to the police by a parent and a copy of the report brought to the school.

If the iPad is stolen as a result of student negligence and the preceding procedure is followed, the student/parent will be responsible for a $100 replacement cost instead of a deductible.

If the iPad is lost, the student/parent is responsible for the Fair Market Value of the iPad (as determined by Apple, Inc.).

The full price of a replacement iPad will be charged if deliberately damaged or vandalized by the student or if damaged occurred while the iPad was out of the district-issued case.

When: Insurance policies are good for 1 school year and must be renewed yearly. If a student has no claims for 3 consecutive years, their insurance policy fee will be waived on their 4th year of renewal and subsequent years. This waiver will lapse the year after a claim is made.

Where: iPad Insurance Policies can be paid at any time prior to iPad distribution in the High School Office, Elementary Office, or Central Office. Please make checks payable to Orrick Schools. The office will issue you a receipt for proof of payment. Be sure to keep this receipt in the event of clerical error.

What Else:

- Policyholders have a duty to be truthful and honest in any information regarding claims. It is their responsibility to provide complete and accurate information to the district. If relevant information is not revealed, the consequences may be that the policy is void and any claim made may be invalidated. Please note that in respect of claims, the district will not accept any changes to a claim form after its original

submission.

- Policies cannot be cancelled and refunds may only be requested through Central Office if a student is moving and has been in the district less than one (1) quarter.
- Policyholders shall take all reasonable precautions to prevent the occurrence of an insured event. This policy shall be voidable in the event of:
  - ➢ Misrepresentation, misdescription, or nondisclosure by the policyholder of any information relating to a claim.
  - ➢ Fraudulent claims: if the policyholder or anyone acting for the policyholder makes a claim under the policy knowing the claim to be false or fraudulently exaggerated in any respect or make a statement in support of a claim knowing the statement to be false in any respect, or submit a document in support of claim knowing the document to be forged or false in any respect, or make a claim in respect of any loss or damage caused by the student's willful act.

I have read the Orrick Elementary & High School Ipad Insurance Policy and agree to its terms. I want to purchase:

_____ Policy A in full _____ Policy A with a payment plan

_____ Policy B in full _____ Policy B with a payment plan

_____ _____

Parent/Guardian Signature Date

_____ _____

Student Signature Date

Orrick School District Activities Consent Form

NAME_____ GRADE_____ BIRTHDATE_____

This application to participate in interscholastic activities at Orrick School District is voluntary on my part and is made with the understanding that I am eligible under the following rules set by MSHSAA and the additional rules set by the Orrick School District. Any questions please see the student/activity handbook.

MSHSAA ELIGIBILITY STANDARDS

1. You must be a creditable school citizen.
2. You cannot be 19 years old before July 1 preceding opening of school.
3. You cannot have graduated from a four year high school.
4. You cannot have attended eight semesters of high school.
5. You cannot have completed in four seasons of a particular sport.
6. You must have attended school the first 11 days of the semester that you are participating in.
7. You cannot have played under a false name.
8. You cannot commit an unsportsmanlike act.
9. Students serving school suspensions are not eligible to practice or compete in school activities.
10. You must be enrolled in courses offering 3.5 units of credit.
11. You must have earned 3.5 units of 80% of credit the preceding semester whichever is greater. Summer school credits may apply to state eligibility standards.

I UNDERSTAND THAT VIOLATION OF ANY OF THE RULES PUBLISHED IN THIS HANDBOOK IS GROUNDS FOR DISMISSAL FROM THE ACTIVITY.

CONSENT TO PARTICIPATION/RISK ACKNOWLEDGMENT

My/our child wishes to participate in the Orrick Activities program. I/we realize that there are risks involved in my/our child's participation. I/we understand that risk to my/our child includes a full range of injuries, from minor to severe, and that the result could death, paralysis, or other serious, permanent disability. I/we agree to accept this risk as a condition of my/our child's participation.

_____ _____

Student's signature Parent/Guardian Signature

Date_____

This form must be on file in the High School office within 10 days of the first day of school in order for students to participate in any athletic and/or extra-curricular activities for the current school year.

Parent Sportsmanship Agreement

The I-70 conference knows that parents play an important role in helping their own children and other players learn good sportsmanship and self-discipline. Parents must set an example when it comes to demonstrating the importance of working together, sacrificing for the good of the team, enjoying winning, and dealing appropriately with defeat. Parents and spectators should be role models of good behavior at sporting events.

Parents and Spectators are expected to:

1. Cheer for your team and refrain from booing or other similar comments.
2. Treat players, coaches, opponents, and officials with respect.
3. It is okay to react to a call that doesn't go your team's way, but do not dwell on the call by continuing to yell at officials.
4. Remember that the primary value of athletic participation is to provide our youth with an opportunity for self-development: physically, emotionally, and mentally.
5. Remember that the game is for the players, not for the adults.
6. Be aware that if a parent conference is desired with the coach that it is HIGHLY inappropriate to speak with the coach regarding this at the conclusion of an event. Wait until the day after the event and call to schedule an appointment.
7. Help maintain a positive atmosphere by influencing your family members and friends to act sportsmanlike.
8. Understand and respect the different roles of parents, coaches and officials. Parents should parent, coaches should coach, officials should officiate and each should be treated with respect.

Failing to show appropriate sportsmanlike behavior will lead to dismissal from any contest and could lead to being suspended from attending further games. The Schools of the I-70 conference promote good sportsmanship. Parents and spectators from each school are expected to show it.

Students Name_____

Parents Name (printed)_____

Parent Signature_____ Date_____

2020-2021 Application for Free and Reduced Price School Meals

Attachment E

Complete one application per household. Please use a pen (not a pencil).

Date Received by LEA (LEA use only) ____________

STEP 1 List ALL Household Members who are infants, children, and students up to and including grade 12 (If more spaces are required for additional names, attach another sheet of paper)

Definition of Household Member: "Anyone who is living with you and shares income and expenses, even if not related."

Children in Foster care and children who meet the definition of Homeless, Migrant or Runaway are eligible for free meals. Read How to Apply for Free and Reduced Price School Meals for more information.

Child's First Name	MI	Child's Last Name	Building Name	Grade	Foster Child	Homeless Migrant Runaway

STEP 2 Do any Household Members (including you) currently participate in one or more of the following assistance programs: SNAP, TANF, or FDPIR? Circle one: Yes / No

If you answered NO > Complete STEP 3. **If you answered YES >** Write a case number here then go to STEP 4 (Do not complete STEP 3) **Case Number:** ____________ Write only one case number in this space

STEP 3 Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)

Are you unsure what income to include here?

Flip the page and review the charts titled "Sources of Income" for more information.

The "Sources of Income for Children" chart will help you with the Child Income section.

The "Sources of Income for Adults" chart will help you with the All Adult Household Members section.

A. Child Income

Sometimes children in the household earn income. Please include the TOTAL gross income earned by all children listed in STEP 1 here.

Child income	How often? Weekly	Bi-Weekly	2x Month	Monthly
$	○	○	○	○

B. All Adult Household Members (including yourself)

List all Household Members not listed in STEP 1 (including yourself) **even if they do not receive income.** For each Household Member listed, if they do receive income, report gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Adult Household Members (First and Last)	Earnings from Work	How often? Weekly	Bi-Weekly	2x Month	Monthly	Public Assistance/ Child Support/Alimony	How often? Weekly	Bi-Weekly	2x Month	Monthly	Pensions/Retirement/ All Other Income	How often? Weekly	Bi-Weekly	2x Month	Monthly
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○

Total Household Members (Children and Adults) ____

Last four digit of Social Security Number (SSN) of primary wage earner or other adult household member. X X X - X X - ____ Check if no SSN ☐

STEP 4 Contact Information and adult signature **Mail Completed Form To: Orrick School District- 100 Kirkham St. Orrick, Mo 64077**

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that school officials may verify (check) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Street Address (if available) ____ Apt # ____ City ____ State ____ Zip ____ Daytime Phone and Email (optional) ____

Printed name of adult completing the form ____ Signature of adult completing the form ____ Today's date ____

DO NOT FILL OUT THIS SECTION. THIS IS FOR SCHOOL USE ONLY.

ANNUAL INCOME CONVERSION: WEEKLY X 52, EVERY 2 WEEKS X 26, TWICE A MONTH X 24, MONTHLY X 12 (USE ONLY IF MULTIPLE FREQUENCY)

☐Food Stamps/Temporary Assistance Household size:________ Total Income:________ Per: ☐Week ☐Every 2 Weeks ☐Twice a Month ☐Month ☐Year

Eligibility: ☐Free ☐Reduced ☐Denied Reason:________ Date withdrawn:________

Determining Official's Signature:________ Date Approved/Denied:________

Confirming Official's Signature (For verification purposes only):________ Date:____

INSTRUCTIONS Sources of Income

Sources of Income for Children

Sources of Child Income	Example(s)
- Earnings from work	- A child has a regular full or part-time job where they earn a salary or wages
- Social Security - Disability Payments - Survivor's Benefits	- A child is blind or disabled and receives Social Security benefits - A Parent is disabled, retired, or deceased, and their child receives Social Security benefits
- Income from person outside the household	- A friend or extended family member regularly gives a child spending money
- Income from any other source	- A child receives regular income from a private pension fund, annuity, or trust

Sources of Income for Adults

Earnings from Work	Public Assistance/ Alimony/Child Support	Pensions / Retirement / All Other Income
- Salary, wages, cash bonuses - Net income from self-employment (farm or business) If you are in the U.S. Military: - Basic pay and cash bonuses (do NOT include combat pay, FSSA or privatized housing allowances) - Allowances for off-base housing, food and clothing	- Unemployment benefits - Worker's compensation - Supplemental Security Income (SSI) - Cash assistance from State or local government - Alimony payments - Child support payments - Veteran's benefits - Strike benefits	- Social Security (including railroad retirement and black lung benefits) - Private pensions or disability benefits - Regular income from trusts or estates - Annuities - Investment income - Earned interest - Rental income - Regular cash payments from outside household

OPTIONAL Children's Racial and Ethnic Identities

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for free or reduced price meals. If ethnicity/race is not selected, a visual identification will be determined.

Ethnicity (check one): ❑ Hispanic or Latino ❑ Not Hispanic or Latino

Race (check one or more): ❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ White

The **Richard B. Russell National School Lunch Act** requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.