



# *LWHS BAND*

## **Handbook Acknowledgement Form**

I have read the band handbook and am familiar with all guidelines stated therein. I will be available for all scheduled rehearsals and performances as listed and on the LWISD Band website and I will adhere to Lake Worth ISD, Lake Worth High School, and Bullfrog Band policies. Any exceptions must be approved by the band staff. I also commit my time and energy to a positive experience in the Bullfrog Band.

Student Name: (print) \_\_\_\_\_ Student Signature: (sign) \_\_\_\_\_

Parent Name: (print) \_\_\_\_\_ Parent(s) Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Name \_\_\_\_\_ Marching Instrument \_\_\_\_\_



**ORDER FORM**

Item	Needed	Size
BMB Shirt	<input type="checkbox"/>	
BMB Shorts	<input type="checkbox"/>	
BMB Shoes	<input type="checkbox"/>	

**SUPPLIES INVOICE**

Item	Check if Needed	Amount
BMB24 Activity Fee	✓	\$100.00
BMB Shorts	<input type="checkbox"/>	\$20.00
BMB Shoes (New)	<input type="checkbox"/>	\$30.00
BMB Shoes (Used)	<input type="checkbox"/>	\$10.00
Percussion Fee / Guard Fee	<input type="checkbox"/>	\$40.00
Instrument Maintenance Fee	<input type="checkbox"/>	\$40.00
<b>TOTAL</b>		

*Do not write below this line* \_\_\_\_\_

Amount Paid : \_\_\_\_\_ Description \_\_\_\_\_

Amount Owed : \_\_\_\_\_

-----  
BMB24 Supplies

Student Name : \_\_\_\_\_

Date : \_\_\_\_\_

Amount Paid : \_\_\_\_\_

Signed : \_\_\_\_\_



# LWHS BAND



## Student Information/Medical Release Form

Student Name :	Grade :
Address :	City/Zip :
Home Phone :	Student Cell :
Student Email	

Parent /Guardian Name :	Cell # :
Parent Email :	Does the Student Live With This Parent :

Parent /Guardian Name :	Cell # :
Parent Email :	Does the Student Live With This Parent :

### **Medical/Travel Release**

I, the undersigned, do hereby authorize the officials and sponsors of the Lake Worth ISD Bands to contact the people listed on this document and authorize the physicians listed in this document to render treatment that may be deemed necessary for the health of the said child. In the event that the people listed or physicians listed are not available, I authorize the officials and sponsors of the LWISD Band to take whatever action is deemed necessary by their judgement for the health of said child. I understand that LWISD and the Band Sponsors will not be financially responsible for the transportation or medical costs incurred by the student.

Known Medical Problems	
Allergies	
Prescription & Over-the-counter medicines used	
Child's Physician and Phone #	
Insurance Information	
Party Responsible for Payment	

\_\_\_\_\_  
Parent/Guardian (Print)

\_\_\_\_\_  
Parent/Guardian (Signature)

\_\_\_\_\_



# LWHS BAND



## Parent Involvement Form

\_\_\_\_\_  
Parent Name

\_\_\_\_\_  
Student Name

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Email Address

**Please circle the activity (ies) in which you would like to participate:**

Chaperone

Uniforms

Marching Band Field Crew

Concession Stand

Concert Preparation

**Best time available:**

Before School

Evenings

During School

Weekends

After School Any Time

## Lake Worth ISD District Owned Instrument Use Agreement

With this agreement to use a district owned band instrument, parents and students assume responsibility and accountability for its use and care. Due to the significant cost of purchasing and maintaining band instruments, certain fees are necessary to maintain the useful life of our instruments.

By signing this form, I agree to the \$40.00 district maintenance fee. I do understand and agree that this does not cover willful, negligent, or accidental damage to the instrument. In the event the instrument is damaged beyond normal wear, a 20% deductible will be charged to the student. A student who repeatedly or intentionally damages an instrument may be held liable for the entire cost of repair or replacement of the instrument.

\_\_\_\_\_  
Student Name

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Name

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

**PARENT/STUDENT UIL MARCHING BAND  
ACKNOWLEDGEMENT FORM**

*Updated 2018*

No student may be required to attend a marching band related practice for more than eight hours outside the academic school day per calendar week (Sunday through Saturday). This provision applies to students in all components of the marching band. **Exception:** For schools that begin instruction prior to the fourth Monday in August the limit of eight hours of rehearsal outside of the academic school day per calendar week shall begin on the Tuesday immediately following Labor Day. Schools under this exception shall be limited to eight hours of rehearsal outside of the academic day per school week (12:01 AM on the first day of school of the calendar week through the end of the school day on the last day of instruction of the school week) until the Tuesday immediately following Labor Day.

On performance days (football games, competitions and other public performances) bands may hold up to one additional hour of warm-up and practice beyond the scheduled warm-up time. Multiple performances on the same day do not allow for additional practice and/or warm-up time.

Examples of Activities Subject to the UIL Marching Band Eight Hour Rule.

- Marching Band Rehearsal (Both Full Band and Components)
- Any Marching Band Group Instructional Activity
- Breaks
- Announcements
- Debriefing and Viewing Marching Band Videos
- Passing Off Marching Band Music
- Marching Band Sectionals (Both Director and Student Led)
- Clinics for The Marching Band or Any of its Components

The Following Activities Are Not Included in the Eight Hour Time Allotment:

- Travel Time to and From Rehearsals and/or Performances
- Rehearsal Set-Up Time
- Pep Rallies, Parades and Other Public Performances
- Instruction and Practice For Music Activities Other Than Marching Band And Its Components

NOTE: More information about Marching Band practice limitations can be found at:  
[www.uiltexas.org/music/marching-band](http://www.uiltexas.org/music/marching-band)

“We have read and understand the Eight-Hour Rule for Marching Band as stated above and agree to abide by these regulations.”

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

This form is to be kept on file by the local school district.

**PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY**

This **MEDICAL HISTORY FORM** must be completed *annually* by parent (or guardian) and student in order for the student to participate in athletic activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an athletic event.

Student's Name: (print) \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_  
 Grade \_\_\_\_\_ School \_\_\_\_\_  
 Personal Physician \_\_\_\_\_ Phone \_\_\_\_\_

*In case of emergency, contact:*

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_

Explain "Yes" answers in the box below\*\*. Circle questions you don't know the answers to.

<p>1. Have you had a medical illness or injury since your last check up or sports physical? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you been hospitalized overnight in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Have you ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Have you ever had prior testing for the heart ordered by a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Have you ever passed out during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Have you ever had chest pain during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Do you get tired more quickly than your friends do during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Have you ever had racing of your heart or skipped heartbeats? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Have you had high blood pressure or high cholesterol? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Have you ever been told you have a heart murmur? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Has any family member or relative died of heart problems or of sudden unexpected death before age 50? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome or other ion channelopathy (Brugada syndrome, etc), Marfan's syndrome, or abnormal heart rhythm? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Has a physician ever denied or restricted your participation in sports for any heart problems? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Have you ever had a head injury or concussion? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Have you ever been knocked out, become unconscious, or lost your memory? <input type="checkbox"/> Yes <input type="checkbox"/> No                  If yes, how many times? _____                  When was your last concussion? _____                  How severe was each one? (Explain below) _____                  Have you ever had a seizure? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Do you have frequent or severe headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Have you ever had numbness or tingling in your arms, hands, legs or feet? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Have you ever had a stinger, burner, or pinched nerve? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Are you missing any paired organs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Are you under a doctor's care? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Have you ever been dizzy during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Have you ever become ill from exercising in the heat? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Have you had any problems with your eyes or vision? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b>Yes</b></p> <p><b>No</b></p>	<p>13. Have you ever gotten unexpectedly short of breath with exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Do you have asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Do you have seasonal allergies that require medical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>15. Have you ever had a sprain, strain, or swelling after injury? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Have you broken or fractured any bones or dislocated any joints? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? <input type="checkbox"/> Yes <input type="checkbox"/> No                  If yes, check appropriate box and explain below:</p> <table border="0" style="width:100%;"> <tr> <td><input type="checkbox"/> Head</td> <td><input type="checkbox"/> Elbow</td> <td><input type="checkbox"/> Hip</td> </tr> <tr> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/> Forearm</td> <td><input type="checkbox"/> Thigh</td> </tr> <tr> <td><input type="checkbox"/> Back</td> <td><input type="checkbox"/> Wrist</td> <td><input type="checkbox"/> Knee</td> </tr> <tr> <td><input type="checkbox"/> Chest</td> <td><input type="checkbox"/> Hand</td> <td><input type="checkbox"/> Shin/Calf</td> </tr> <tr> <td><input type="checkbox"/> Shoulder</td> <td><input type="checkbox"/> Finger</td> <td><input type="checkbox"/> Ankle</td> </tr> <tr> <td><input type="checkbox"/> Upper Arm</td> <td><input type="checkbox"/> Foot</td> <td></td> </tr> </table> <p>16. Do you want to weigh more or less than you do now? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>17. Do you feel stressed out? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>Females Only</i></p> <p>19. When was your first menstrual period? _____                  When was your most recent menstrual period? _____                  How much time do you usually have from the start of one period to the start of another? _____                  How many periods have you had in the last year? _____                  What was the longest time between periods in the last year? _____</p> <p><i>Males Only</i></p> <p>20. Do you have two testicles? _____</p> <p>21. Do you have any testicular swelling or masses? _____</p>	<input type="checkbox"/> Head	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip	<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh	<input type="checkbox"/> Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Knee	<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Shin/Calf	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger	<input type="checkbox"/> Ankle	<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Foot		<p><b>Yes</b></p> <p><b>No</b></p>
<input type="checkbox"/> Head	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip																			
<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh																			
<input type="checkbox"/> Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Knee																			
<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Shin/Calf																			
<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger	<input type="checkbox"/> Ankle																			
<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Foot																				

**An individual answering in the affirmative to any question relating to a possible cardiovascular health issue (question three above), as identified on the form, should be restricted from further participation until the individual is examined and cleared by a physician, physician assistant, chiropractor, or nurse practitioner.**

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**\*\*EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary):**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

It is understood that even though protective equipment is worn by the athlete, whenever needed, the possibility of an accident still remains. Neither the University Interscholastic League nor the school assumes any responsibility in case an accident occurs.

If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student.

If, between this date and the beginning of athletic competition, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury.

**I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide truthful responses could subject the student in question to penalties determined by the UIL**

Student Signature: \_\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Any Yes answer to questions 1, 2, 3, 4, 5, or 6 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physician assistant, chiropractor, or nurse practitioner is required before any participation in UIL practices, games or matches. THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE OR CONTEST BEFORE, DURING OR AFTER SCHOOL.**

**For School Use Only:**

This Medical History Form was reviewed by: Printed Name \_\_\_\_\_ Date \_\_\_\_\_ Signature \_\_\_\_\_

**PREPARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAMINATION**

Student's Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ % Body fat (optional) \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_/\_\_\_\_ (\_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_)  
brachial blood pressure while sitting

Vision: R 20/\_\_\_\_ L 20/\_\_\_\_ Corrected:  Y  N Pupils:  Equal  Unequal

As a minimum requirement, this **Physical Examination Form** must be completed prior to junior high athletic participation and again prior to first and third years of high school athletic participation. It **must** be completed if there are yes answers to specific questions on the student's MEDICAL HISTORY FORM on the reverse side. \* **Local district policy may require an annual physical exam.**

	NORMAL	ABNORMAL FINDINGS	INITIALS*
<b>MEDICAL</b>			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in the supine position.			
Heart-Auscultation of the heart in the standing position.			
Heart-Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			

**MUSCULOSKELETAL**

Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

\*station-based examination only

**CLEARANCE**

Cleared  
 Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_

Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_

*The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner, will not be accepted.*

Name (print/type) \_\_\_\_\_ Date of Examination: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Signature: \_\_\_\_\_

Must be completed before a student participates in any practice, before, during or after school, (both in-season and out-of-season) or games/matches.