

LITTLEFIELD UNIFIED SCHOOL DISTRICT

BEAVER DAM JUNIOR/SENIOR HIGH SCHOOL ATHLETIC PACKET

STUDENT INFORMATION

Revised April 14, 2025

Student's Last Name: _____ First Name: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Street Address: (If Different) _____ City: _____ Zip: _____
Home Phone: _____ Student's Cell: _____
Mother's Name: _____ Mother's Cell: _____
Father's Name: _____ Father's Cell: _____
Are Parents Separated? Yes _____ No _____ Divorced? Yes _____ No _____
If yes, which parent is the custodial parent? Mother _____ Father _____
Guardian's Name: _____ Guardian's Cell: _____

CIRCLE THE SPORTS BELOW THAT YOU PLAN TO PARTICIPATE IN

Football Volleyball HS Basketball Wrestling MS Basketball Baseball Softball Cheer

CHECKLIST

(The following items are to be returned to the Athletic Director unless noted to stay with Doctor.)

- _____ Student Information and Checklist
- _____ Page 1 & 2 History Form - English (both sides completed by athlete and parent/guardian) – **stays with Doctor**
- _____ Page 3 & 4 History Form – Spanish (both sides completed by athlete and parent/guardian) – **stays with Doctor**
- _____ Page 5 & 6 Physical Examination Form and Athletes with Disabilities Form (two pages/back-to-back) – **stays with Doctor**
- _____ Page 7 Medical Eligibility Form – return to school with packet
- _____ Page 8 Field Trip Approval and Proof of Insurance (to be completed if your child is covered under a health insurance plan)
- _____ Page 9 Emergency Transportation Approval and Drug/Alcohol/Substance Use
- _____ Page 10 Residency Statement
- _____ Page 11 NIAA Concussion Prevention, Management and Treatment Policy Acknowledgement Form
- _____ **HS Athletes ONLY** – Register My Athlete – Aktivite
- _____ Sports fee paid for each sport participating in \$25. 00 per sport – **MUST BE PAID BEFORE PARTICIPATING & INITIALED BY OFFICE MANAGER**

(The following items are being given to parents for informational purposes and are to be kept at home)

- NIAA Concussion Prevention, treatment and Management Policy
- Concussion fact sheets for Parents and students (in English and Spanish)
- Catastrophic Medical Insurance information (in English and Spanish)
- NIAA Alcohol, Tobacco and other Drug Possession use abuse and penalties policy
- Register My Athlete (Aktivate) – Instructions for Parents
- Application for Financial Assistance (if applying, follow directions. This form is NOT returned to the school.)

DISTRITO ESCOLAR UNIFICADO DE LITTLEFIELD

PAQUETE ATLÉTICO BEAVER DAM JUNIOR/SENIOR HIGH SCHOOL

INFORMACIÓN DEL ESTUDIANTE

Revisado el 14 de abril de 2025

Apellido del estudiante: _____ Nombre: _____
Dirección postal: _____ Ciudad: _____ Estado: Código postal: _____
Dirección: (si es diferente) _____ Ciudad: _____ Código postal _____
Teléfono de casa: _____ Celular del estudiante: _____
Nombre de la madre: _____ Celular de la madre: _____
Nombre del padre: _____ Celular del padre: _____
¿Están los padres separados? Sí _____ No _____ ¿Divorciado? Sí _____ No _____
En caso afirmativo, ¿cuál de los padres es el padre con custodia? Madre _____ padre _____
Nombre del tutor: _____ Celda del tutor _____

MARQUE CON UN CÍRCULO LOS DEPORTES A CONTINUACIÓN EN LOS QUE PLANEA PARTICIPAR

Fútbol Voleibol Baloncesto HS Lucha MS Baloncesto Béisbol Softbol Alegría

LISTA DE VERIFICACIÓN

(Los siguientes artículos deben ser devueltos al Director Atlético a menos que se indique que se queden con el Doctor).

- _____ Información del estudiante y lista de verificación
- _____ Página 1 y 2 Formulario de historial-Inglés (ambos lados completados por el atleta y el padre/tutor) - **se queda con el médico**
- _____ Página 3y4 Formulario de Historial-Español (ambos lados completados por el atleta y el padre/tutor)-**se queda con el Doctor**
- _____ Páginas 5 y 6 Formulario de examen físico y formulario de atletas con discapacidades (dos páginas/espalda con espalda) - **se queda con el médico**
- _____ Página 7 Formulario de elegibilidad médica: devuélvalo a la escuela con el paquete
- _____ Página 8 Aprobación de viaje de campo y prueba de seguro (para completar si su hijo está cubierto por un plan de seguro médico)
- _____ Página 9 Aprobación de Transporte de Emergencia y Uso de Drogas/Alcohol/Sustancias
- _____ Página 10 Declaración de residencia
- _____ Página 11 Formulario de acuse de recibo de la política de prevención, manejo y tratamiento de conmociones cerebrales de NIAA
- _____ **Atletas de HS SOLAMENTE** - Register My Athlete - Activate
- _____ Tarifa deportiva pagada por cada deporte que participe en \$25. 00 por deporte - **DEBE PAGAR ANTES DE PARTICIPAR Y INICIALIZADO POR EL ADMINISTRADOR DE LA OFICINA**

(Los siguientes artículos se entregan a los padres con fines informativos y deben mantenerse en casa)

- Política de prevención, tratamiento y gestión de conmociones cerebrales del NIAA
- Hojas informativas sobre conmociones cerebrales para padres y estudiantes (en inglés y español)
- Información del Seguro Médico Catastrófico (en inglés y español)
- Política de multas y abuso por uso de alcohol, tabaco y otras drogas de NIAA
- Instrucciones para Padres - Register My Athlete (Aktivate)
- Solicitud de asistencia financiera (si solicita, siga las instrucciones. Este formulario NO se devuelve a la escuela)

DO NOT SHARE this form with schools or sports organizations. It should be placed into the athlete's medical file.

The Medical Eligibility Form (PAGE 7) is the only form that should be submitted to a school or sports organization.

Disclaimer: Athletes who have a current Preparticipation Physical Evaluation (per state and local guidance) on file should not need to complete another history form.

■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Birth Sex (M/F): _____ Differences of Sex Development (DSD) Y/N: _____ Comment: _____

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 your allergies (ie, 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.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

DO NOT SHARE this form with schools or sports organizations. It should be placed into the athlete's medical file.

BONE AND JOINT QUESTIONS		Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?			
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?			
MEDICAL QUESTIONS		Yes	No
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?			
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?			
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?			
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)?			
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?			
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?			
22. Have you ever become ill while exercising in the heat?			
23. Do you or does someone in your family have sickle cell trait or disease?			
24. Have you ever had or do you have any problems with your eyes or vision?			

MEDICAL QUESTIONS (CONTINUED)		Yes	No
25. Do you worry about your weight?			
26. Are you trying to or has anyone recommended that you gain or lose weight?			
27. Are you on a special diet or do you avoid certain types of foods or food groups?			
28. Have you ever had an eating disorder?			
FEMALES ONLY		Yes	No
29. Have you ever had a menstrual period?			
30. How old were you when you had your first menstrual period?			
31. When was your most recent menstrual period?			
32. How many periods have you had in the past 12 months?			

Explain "Yes" answers here.

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There are approximately 20 lines visible. The paper appears to be a standard notebook page.

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 or guardian: _____

Date: _____

Este formulario debe colocarse en el expediente médico del atleta y no debe compartirse con escuelas u organizaciones deportivas. El formulario de elegibilidad médica es el único formulario que debe enviarse a una escuela u organización deportiva.

Aviso legal: Los atletas que tengan una evaluación física de preparticipación vigente en el archivo (según los lineamientos generales estatales y locales) no necesitan completar otro formulario de antecedentes.

■ EVALUACIÓN FÍSICA PREVIA A LA PARTICIPACIÓN (orientación provisional)

FORMULARIO DE HISTORIAL CLÍNICO

Nota: Complete y firme este formulario (con la supervisión de sus padres si es menor de 18 años) antes de acudir a su cita.

Nombre: _____ Fecha de nacimiento: _____

Fecha del examen médico: _____ Deporte(s): _____

Sexo de nacimiento (M/F): _____ Diferencias en el Desarrollo Sexual (DSD) Sí/No _____ Comentarios _____

Mencione los padecimientos médicos pasados y actuales que haya tenido. _____

¿Alguna vez se le practicó una cirugía? Si la respuesta es afirmativa, haga una lista de todas sus cirugías previas. _____

Medicamentos y suplementos: Enumere todos los medicamentos recetados, medicamentos de venta libre y suplementos (herbolarios y nutricionales) que consume. _____

¿Sufre de algún tipo de alergia? Si la respuesta es afirmativa, haga una lista de todas sus alergias (por ejemplo, a algún medicamento, al polen, a los alimentos, a las picaduras de insectos). _____

Cuestionario sobre la salud del paciente versión 4 (PHQ-4)

Durante las últimas dos semanas, ¿con qué frecuencia experimentó alguno de los siguientes problemas de salud? (Encierre en un círculo la respuesta)

	Ningún día	Varios días	Más de la mitad de los días	Casi todos los días
Se siente nervioso, ansioso o inquieto	0	1	2	3
No es capaz de detener o controlar la preocupación	0	1	2	3
Siente poco interés o satisfacción por hacer cosas	0	1	2	3
Se siente triste, deprimido o desesperado	0	1	2	3

(Una suma >3 se considera positiva en cualquiera de las subescalas, [preguntas 1 y 2 o preguntas 3 y 4] a fin de obtener un diagnóstico).

PREGUNTAS GENERALES

(Dé una explicación para las preguntas en las que contestó "Sí", en la parte final de este formulario. Encierre en un círculo las preguntas si no sabe la respuesta).

	Sí	No
1. ¿Tiene alguna preocupación que le gustaría discutir con su proveedor de servicios médicos?		
2. ¿Alguna vez un proveedor de servicios médicos le prohibió o restringió practicar deportes por algún motivo?		
3. ¿Padece algún problema médico o enfermedad reciente?		
PREGUNTAS SOBRE SU SALUD CARDIOVASCULAR	Sí	No
4. ¿Alguna vez se desmayó o estuvo a punto de desmayarse mientras hacía, o después de hacer, ejercicio?		

PREGUNTAS SOBRE SU SALUD CARDIOVASCULAR (CONTINUACIÓN)

	Sí	No
5. ¿Alguna vez sintió molestias, dolor, compresión o presión en el pecho mientras hacía ejercicio?		
6. ¿Alguna vez sintió que su corazón se aceleraba, palpitaba en su pecho o latía intermitentemente (con latidos irregulares) mientras hacía ejercicio?		
7. ¿Alguna vez un médico le dijo que tiene problemas cardíacos?		
8. ¿Alguna vez un médico le pidió que se hiciera un examen del corazón? Por ejemplo, electrocardiografía (ECG) o ecocardiografía.		
9. Cuando hace ejercicio, ¿se siente mareado o siente que le falta el aire más que a sus amigos?		
10. ¿Alguna vez tuvo convulsiones?		

Este formulario debe colocarse en el expediente médico del atleta y no debe compartirse con escuelas u organizaciones deportivas.

PREGUNTAS SOBRE LA SALUD CARDIOVASCULAR DE SU FAMILIA	Si	No
11. ¿Alguno de los miembros de su familia o pariente murió debido a problemas cardíacos o tuvo una muerte súbita e inesperada o inexplicable antes de los 35 años de edad (incluyendo muerte por ahogamiento o un accidente automovilístico inexplicable)?		
12. ¿Alguno de los miembros de su familia padece un problema cardíaco genético como la miocardiopatía hipertrófica (HCM), el síndrome de Marfan, la miocardiopatía arritmogénica del ventrículo derecho (ARVC), el síndrome del QT largo (LQTS), el síndrome del QT corto (SQTS), el síndrome de Brugada o la taquicardia ventricular polimórfica catecolaminérgica (CPVT)?		
13. ¿Alguno de los miembros de su familia utilizó un marcapasos o se le implantó un desfibrilador antes de los 35 años?		
PREGUNTAS SOBRE LOS HUESOS Y LAS ARTICULACIONES	Si	No
14. ¿Alguna vez sufrió una fractura por estrés o una lesión en un hueso, músculo, ligamento, articulación o tendón que le hizo faltar a una práctica o juego?		
15. ¿Sufre alguna lesión ósea, muscular, de los ligamentos o de las articulaciones que le causa molestia?		
PREGUNTAS SOBRE CONDICIONES MÉDICAS	Si	No
16. ¿Tose, sibila o experimenta alguna dificultad para respirar durante o después de hacer ejercicio?		
17. ¿Le falta un riñón, un ojo, un testículo (en el caso de los hombres), el bazo o cualquier otro órgano?		
18. ¿Sufre dolor en la ingle o en los testículos, o tiene alguna protuberancia o hernia dolorosa en la zona inguinal?		
19. ¿Padece erupciones cutáneas recurrentes o que aparecen y desaparecen, incluyendo el herpes o Staphylococcus aureus resistente a la metilina (MRSA)?		

PREGUNTAS SOBRE CONDICIONES MÉDICAS (CONTINUACIÓN)	Si	No
20. ¿Alguna vez sufrió un traumatismo craneoencefálico o una lesión en la cabeza que le causó confusión, un dolor de cabeza prolongado o problemas de memoria?		
21. ¿Alguna vez sintió adormecimiento, hormigueo, debilidad en los brazos o piernas, o fue incapaz de mover los brazos o las piernas después de sufrir un golpe o una caída?		
22. ¿Alguna vez se enfermó al realizar ejercicio cuando hacía calor?		
23. ¿Usted o algún miembro de su familia tiene el rasgo drepanocítico o padece una enfermedad drepanocítica?		
24. ¿Alguna vez tuvo o tiene algún problema con sus ojos o su visión?		
25. ¿Le preocupa su peso?		
26. ¿Está tratando de bajar o subir de peso, o alguien le recomendó que baje o suba de peso?		
27. ¿Sigue alguna dieta especial o evita ciertos tipos o grupos de alimentos?		
28. ¿Alguna vez sufrió un desorden alimenticio?		
ÚNICAMENTE MUJERES	Si	No
29. ¿Ha tenido al menos un periodo menstrual?		
30. ¿A los cuántos años tuvo su primer periodo menstrual?		
31. ¿Cuándo fue su periodo menstrual más reciente?		
32. ¿Cuántos periodos menstruales ha tenido en los últimos 12 meses?		

Proporcione una explicación aquí para las preguntas en las que contestó "Si".

Por la presente declaro que, según mis conocimientos, mis respuestas a las preguntas de este formulario están completas y son correctas.

Firma del atleta: _____

Firma del padre o tutor: _____

Fecha: _____

DO NOT SHARE this form with schools or sports organizations. It should be placed into the athlete's medical file.

■ PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

- 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, e-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?
- Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: _____	Weight: _____	Birth Sex (M/F): _____ SRY Screen Result* (optional) ☐ SRY+ ☐ SRY-
BP: _____ / _____ (_____ / _____)	Pulse: _____	Vision: R 20/ _____ L 20/ _____ Corrected: ☐ Y ☐ N
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 <i>Staphylococcus aureus</i> (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		

* A positive SRY result will only be eligible for boy's sports on the Medical Eligibility Form unless cleared to have no male androgenization (e.g. CAIS).

Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, PA or DC

DO NOT SHARE this form with schools or sports organizations. It should be placed into the athlete's medical file.

■ **PREPARTICIPATION PHYSICAL EVALUATION**

ATHLETES WITH DISABILITIES FORM: SUPPLEMENT TO THE ATHLETE HISTORY

Name: _____ Date of birth: _____

1. Type of disability:		
2. Date of disability:		
3. Classification (if available):		
4. Cause of disability (birth, disease, injury, or other):		
5. List the sports you are playing:		
	Yes	No
6. Do you regularly use a brace, an assistive device, or a prosthetic device for daily activities?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed as having a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "Yes" answers here.

Please indicate whether you have ever had any of the following conditions:

	Yes	No
Atlantoaxial instability		
Radiographic (x-ray) evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "Yes" answers here.

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 or guardian: _____

Date: _____

Submit this form ONLY (page 7) to the school or sports organization.

■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____ Date of exam: _____

Birth Sex (M/F): _____ ☐ Medically eligible for girls sports ☐ Medically eligible for boys sports

"Male" means a person belonging to the sex intended to produce the small reproductive cell. "Female" means a person intended to produce the large reproductive cell.

I have reviewed the History Form for the student named on this form and will provide all relevant information below. The information provided below will be used to assist athletic personnel, which may include but is not limited to an athletic administrator, athletic director, and/or athletic trainer, in the supervision and treatment of the student named on this form.

INITIALS of Health Care Professional: _____

Allergies: _____

Medications: _____

Medical Conditions and/or Surgeries: _____

Any relevant YES answers on History Form: _____

MARK ONE:

- ☐ Medically eligible for all sports without restriction
- ☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of _____
- ☐ Medically eligible for certain sports _____
- ☐ Not medically eligible pending further evaluation
- ☐ Not medically eligible for any sports

Recommendations: _____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are 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 medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

SIGNATURE of Health Care Professional: _____, MD, DO, NP, PA or DC

Health Care Professional License Number: _____

LITTLEFIELD UNIFIED SCHOOL DISTRICT

Field Trip Approval

Revised May 14, 2018

I give permission for my child _____ to attend the athletic trips for the upcoming school year in the sport which they choose to participate in. These athletes are to follow the rules and guidelines as they are given by the coach or supervisor of the sport. Also, parents are responsible for picking up the athlete upon the bus arriving at the end of the trip.

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

DISTRITO ESCOLAR UNIFICADO DE LITTLEFIELD

Aprobación de Viaje de Campo

Revisado el 14 de mayo de 2018

Doy permiso para que mi hijo _____ asista a los viajes deportivos para el próximo año escolar en el deporte en el que elijan participar. Estos atletas deben seguir las reglas y pautas que les da el entrenador o supervisor del deporte. Además, los padres son responsables de recoger al atleta cuando el autobús llegue al final del viaje.

Firma del estudiante: _____ Fecha: _____

Firma del Padre/Tutor: _____ Fecha: _____

LITTLEFIELD UNIFIED SCHOOL DISTRICT

PROOF OF INSURANCE

Revised May 14, 2018

I certify that my child, _____, has full health and accident

Name of Student

Insurance coverage with, _____,

Name of the Insurance Company

Policy Number

Expiration Date of Policy

Signature of Parent or Guardian

Date

DISTRITO ESCOLAR UNIFICADO DE LITTLEFIELD

PRUEBA DE SEGURO

Revisado el 14 de mayo de 2018

Certifico que mi hijo, _____, tiene plena salud y accidentes

Nombre de estudiante

Cobertura de seguro con, _____,

Nombre de la Compañía de Seguros Número de Póliza

Fecha de vencimiento de la póliza

Firma del padre o tutor

Fecha

LITTLEFIELD UNIFIED SCHOOL DISTRICT EMERGENCY TRANSPORTATION APPROVAL

Revised May 14, 2018

This is to certify that I/We, the Parent/s or guardian/s of _____, give permission for school personnel at Beaver Dam High School to call an ambulance or otherwise provide emergency transportation to a doctor or hospital for medical treatment resulting from an accident or illness.

I/We understand that every effort will be made to contact me/us immediately, but should there be difficulty in reaching me/us, I/We will not hold school personnel or Beaver Dam High School responsible for any costs or liabilities associated with such actions.

Parent's Name _____ Signature _____
Print Signature

Date _____ Phone Number _____

DISTRITO ESCOLAR UNIFICADO DE LITTLEFIELD APROBACIÓN DE TRANSPORTE DE EMERGENCIA

Revisado el 14 de mayo de 2018

Esto es para certificar que yo/nosotros, los padres o tutores de _____, damos permiso para que el personal escolar de Beaver Dam High School llame a una ambulancia o proporcione transporte de emergencia a un médico u hospital para recibir tratamiento médico como resultado de un accidente o enfermedad.

Yo/nosotros entendemos que se hará todo lo posible para comunicarse conmigo/nosotros de inmediato, pero si hay dificultades para comunicarse conmigo/nosotros, yo/nosotros no responsabilizaremos al personal de la escuela o a Beaver Dam High School por los costos o responsabilidades asociados con tal comportamiento.

Nombre de los padres _____ Firma _____
Imprimir firma

Fecha _____ Número de teléfono _____

LITTLEFIELD UNIFIED SCHOOL DISTRICT

DRUG/ ALCOHOL/ SUBSTANCE USE

Any student-athlete determined to be in possession of, or to have used tobacco, including smoking tobacco, chewing tobacco or snuff, alcoholic beverages, controlled substances and narcotics as defined by ARS or any local ordinance, or using prescription medication that is prescribed for someone else, will receive disciplinary action. During the school year, students in the presence of these items, whether during school hours, at home or on a school trip, are expected to leave the scene of illegal substance use or the use of prescription medication not prescribed for the person using it, immediately. Failure to do so may result in disciplinary action.

I _____ understand that if I engage in the use of
Student Signature

substances as outlined in the Paragraph above, I will be disciplined for my actions.

Signed on (date) _____

Parent Signature _____ Date _____

DISTRITO ESCOLAR UNIFICADO DE LITTLEFIELD

USO DE DROGAS/ALCOHOL/SUSTANCIAS

Cualquier estudiante-atleta que se determine que está en posesión o ha consumido tabaco, incluido fumar tabaco, masticar tabaco o rapé, bebidas alcohólicas, sustancias controladas y narcóticos según lo define el ARS o cualquier ordenanza local, o usar medicamentos recetados para otra persona, recibirá una acción disciplinaria. Durante el año escolar, se espera que los estudiantes en presencia de estos artículos, ya sea durante el horario escolar, en casa o en un viaje escolar, abandonen la escena del uso de sustancias ilegales o el uso de medicamentos recetados no recetados para la persona que los usa. inmediatamente. El no hacerlo puede resultar en una acción disciplinaria.

Yo _____ entiendo que si participo en el uso de
Firma del alumno

sustancias como se describe en el párrafo anterior, seré disciplinado por mis acciones.

Firmado el (fecha) _____

Firma del padre _____ Fecha _____

LITTLEFIELD UNIFIED SCHOOL DISTRICT

RESIDENCY/CUSTODY

STATEMENT

Revised May 14, 2018

To be eligible athletic participation, parents/guardians must comply with the residency and custody regulations set forth by the Littlefield Unified School District and the Nevada Interscholastic Activities Association (NIAA) NRS 386.430. Please read the statements below and provide both parent and student initials on the spaces to the left, indicating you have read each item.

Parent
Initials

Student
Initials

- | | |
|-------|---|
| _____ | _____ We understand this student must reside with a parent in the attendance zone of the high school as listed on the Athletic packet. Failure to do so is considered an attempt to circumvent residency policies and may result in loss of eligibility and forfeitures. |
| _____ | _____ We understand that if we move to another attendance zone, we must entirely abandon our former residence to be eligible for high school athletics in the new zone. |
| _____ | _____ We understand that notarized guardianships and parent appointed guardianships are not accepted for athletic eligibility. |
| _____ | _____ We understand that if a parent/guardian is separated, the student's athletic eligibility will remain in the current school of enrollment. |
| _____ | _____ We understand if a parent/guardian is divorced, the student's eligibility is in the zone of the primary custodial parent or remains in the current school of enrollment. |
| _____ | _____ We understand falsification of any portion of the Athletic Packet may result in the loss of athletic eligibility for up to 360 school days (two years), as well as forfeiture of games has a serious effect on all members of a team and should not be taken lightly. |

DISTRITO ESCOLAR UNIFICADO DE LITTLEFIELD

RESIDENCIA/CUSTODIA

DECLARACIÓN

Revisado el 14 de mayo de 2018

Para ser elegible para la participación atlética, los padres/tutores deben cumplir con las normas de residencia y custodia establecidas por el Distrito Escolar Unificado de Littlefield y la Asociación de Actividades Interescolares de Nevada (NIAA) NRS 386.430. Lea las declaraciones a continuación y proporcione las iniciales del padre y del estudiante en los espacios a la izquierda, lo que indica que ha leído cada elemento.

Padre
Iniciales

Estudiante
Iniciales

_____ Entendemos que este estudiante debe residir con un padre en el zona de asistencia de la escuela secundaria como se indica en el Athletic paquete. No hacerlo se considera un intento de eludir políticas de residencia y puede resultar en la pérdida de elegibilidad y decomisos

_____ Entendemos que si nos mudamos a otra zona de asistencia, debe abandonar por completo nuestra antigua residencia para ser elegible para el atletismo de la escuela secundaria en la nueva zona.

_____ Entendemos que las tutelas notariadas y las tutelas designadas por los padres no se aceptan para la elegibilidad atlética.

_____ Entendemos que si un padre/tutor se separa, la elegibilidad atlética del estudiante permanecerá en la escuela de inscripción actual.

_____ Entendemos que si un padre/tutor está divorciado, la elegibilidad del estudiante está en la zona del padre con custodia principal o permanece en la escuela de inscripción actual.

_____ Entendemos que la falsificación de cualquier parte del Paquete Atlético puede resultar en la pérdida de la elegibilidad atlética por hasta 360 días escolares (dos años), así como la pérdida de juegos tiene un efecto grave en todos los miembros de un equipo y no debe tomarse. ligeramente.



NIAA CONCUSSION PREVENTION, TREATMENT AND MANAGEMENT POLICY

Participation in NIAA sanctioned sports is a privilege and responsibility which requires all participants to adhere to athletic training rules imposed by the Nevada Interscholastic Activities Association ("NIAA"), as well as the school district and member, affiliate or provisional school the student attends and represents. Adherence to training rules ensures that all student athletes are in top physical condition, minimizes potential for significant injury, and further ensures that all member and affiliate school athletic teams are protected and properly represented by their student athletes.

A concussion is a brain injury that results from a bump, blow or jolt to the head or body which causes the brain to move rapidly in the skull and which disrupts normal brain function. The Centers for Disease Control and Prevention of the United States Department of Health and Human Services estimates that as many as 3.8 million concussions occur each year in the United States which are related to participation in sports and other recreational activities. Student athletes who continue to participate in an athletic activity while suffering from a concussion or suffering from the symptoms of an injury to the head are at a greater risk for catastrophic injury to the brain or even death. Ensuring that a student athlete who sustains or is suspected of sustaining a concussion or other injury to the head receives the appropriate medical care before returning to an athletic activity will significantly reduce the child's risk of sustaining greater injury in the future.

The Nevada Legislature passed AB455, now codified at NRS 386.435, during the 2011 Legislative session which mandates the NIAA develop a policy addressing concussion prevention, treatment and management which applies to all sports and activities sanctioned by the NIAA.

THEREFORE, the NIAA hereby adopts the following policy for purposes of prevention, treatment and management of injuries to the head which may occur during a pupil's participation in interscholastic activities and events, including, without limitation, a concussion of the brain. This policy constitutes the minimum standard that all member schools shall follow. School Districts and member schools may choose to adopt and follow more stringent programs and guidelines pertaining to the prevention, treatment and management of concussions and those programs shall take precedence over this policy.

1. Each school year before a student athlete is allowed to participate in an Interscholastic activity or event, the student athlete and his or her parent or legal guardian must be provided with a copy of this policy. Participation in interscholastic activities or events shall be construed in accordance with the definition of "participation" as set forth in NAC 386.615 and 386.695.
2. The student athlete and his or her parent or legal guardian must sign the statement attached to this policy acknowledging that they have read and understand the terms and conditions of the policy, and agree to be bound by the policy.

3. If a student athlete sustains, or is suspected of sustaining, an injury to the head while participating in any NIAA activity or event the pupil must:
- (a) Be immediately removed from the activity or event; and
 - (b) May only return to the activity or event if the parent or legal guardian of the student athlete first provides the athletic administrator of the member school a signed statement from a provider of health care indicating that the student athlete is medically cleared for participation in the activity or event. The statement must include the date on which the pupil may return to the activity or event.
 - (c) "Provider of health care," as used in (b), above, means a physician licensed under Chapter 630 or 633 of the Nevada Revised Statutes ("NRS"), a physical therapist licensed under Chapter 640 of NRS or an athletic trainer licensed under Chapter 640B of NRS.

PARENT & ATHLETE CONCUSSION INFORMATION SHEET



WHAT IS A CONCUSSION?

A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by a bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

WHAT ARE THE SIGNS AND SYMPTOMS OF CONCUSSION?

Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury.

If an athlete reports one or more symptoms of concussion after a bump, blow, or jolt to the head or body, s/he should be kept out of play the day of the injury. The athlete should only return to play with permission from a health care professional experienced in evaluating for concussion.

DID YOU KNOW?

- Most concussions occur without loss of consciousness.
- Athletes who have, at any point in their lives, had a concussion have an increased risk for another concussion.
- Young children and teens are more likely to get a concussion and take longer to recover than adults.

[INSERT YOUR LOGO]

SYMPTOMS REPORTED BY ATHLETE:

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light
- Sensitivity to noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Just not "feeling right" or is "feeling down"

SIGNS OBSERVED BY COACHING STAFF:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes
- Can't recall events prior to hit or fall
- Can't recall events after hit or fall



**"IT'S BETTER TO MISS ONE GAME
THAN THE WHOLE SEASON"**

CONCUSSION DANGER SIGNS

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. An athlete should receive immediate medical attention if after a bump, blow, or jolt to the head or body s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that gets worse
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people or places
- Becomes increasingly confused, restless, or agitated
- Has unusual behavior
- Loses consciousness (even a brief loss of consciousness should be taken seriously)

WHAT SHOULD YOU DO IF YOU THINK YOUR ATHLETE HAS A CONCUSSION?

1. If you suspect that an athlete has a concussion, remove the athlete from play and seek medical attention. Do not try to judge the severity of the injury yourself. Keep the athlete out of play the day of the injury and until a health care professional, experienced in evaluating for concussion, says s/he is symptom-free and it's OK to return to play.
2. Rest is key to helping an athlete recover from a concussion. Exercising or activities that involve a lot of concentration, such as studying, working on the computer, and playing video games, may cause concussion symptoms to reappear or get worse. After a concussion, returning to sports and school is a gradual process that should be carefully managed and monitored by a health care professional.
3. Remember: Concussions affect people differently. While most athletes with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer.

WHY SHOULD AN ATHLETE REPORT THEIR SYMPTOMS?

If an athlete has a concussion, his/her brain needs time to heal. While an athlete's brain is still healing, s/he is much more likely to have another concussion. Repeat concussions can increase the time it takes to recover. In rare cases, repeat concussions in young athletes can result in brain swelling or permanent damage to their brain. They can even be fatal.

STUDENT-ATHLETE NAME PRINTED

STUDENT-ATHLETE NAME SIGNED

DATE

PARENT OR GUARDIAN NAME PRINTED

PARENT OR GUARDIAN NAME SIGNED

DATE

JOIN THE CONVERSATION  www.facebook.com/CDCHeadsUp



HEADS UP

TO LEARN MORE GO TO >> WWW.CDC.GOV/CONCUSSION

Content Source: CDC's Heads Up Program. Created through a grant to the CDC Foundation from the National Operating Committee on Standards for Athletic Equipment (NOCSEAE).

Hoja informativa para **PADRES DE ESTUDIANTES DE ESCUELA SECUNDARIA**



Esta hoja contiene información para ayudarle a proteger a los adolescentes de una conmoción cerebral u otra lesión cerebral grave.

¿Qué es una conmoción cerebral?

Una conmoción cerebral es un tipo de lesión cerebral traumática o TBI (por sus siglas en inglés) causada por un golpe, impacto o sacudida en la cabeza o por un golpe en el cuerpo que hace que la cabeza y el cerebro se muevan rápida y repentinamente hacia adelante y hacia atrás. Este movimiento rápido puede hacer que el cerebro rebote o gire dentro del cráneo y provoque cambios químicos en el cerebro, y a veces hace que las células cerebrales se estiren y se dañen.

¿Cómo puedo mantener a mi hijo adolescente a salvo?

Los deportes son una buena manera para que los adolescentes se mantengan saludables y los ayudan a que les vaya bien en la escuela. Para ayudar a reducir la probabilidad de que su hijo adolescente tenga una conmoción cerebral, usted debe:

- Ayudar a crear una cultura de seguridad para el equipo.
 - Junto con el entrenador, enséñele maneras de disminuir las probabilidades de sufrir una conmoción cerebral.
 - Ponga énfasis en la importancia de notificar las conmociones cerebrales y tomarse el tiempo para recuperarse de estas.
 - Asegúrese de que siga las reglas de seguridad del entrenador y las reglas del deporte.
 - Explíquelo a su hijo adolescente que espera que mantenga el espíritu deportivo en todo momento.
- Cuando sea adecuado para el deporte o la actividad, enséñele a que debe usar un casco para disminuir su probabilidad de sufrir los tipos más graves de lesiones en la cabeza o el cerebro. No existe un casco "a prueba" de lesiones cerebrales. Incluso con un casco, es importante que los adolescentes eviten golpes en la cabeza.

¿Cómo puedo identificar una posible conmoción cerebral?

Los adolescentes que muestran o notifican uno o más signos y síntomas enumerados a continuación, o simplemente dicen que no se "sienten del todo bien" después de un golpe, impacto o sacudida en la cabeza o el cuerpo, podrían tener una conmoción cerebral u otra lesión cerebral grave.

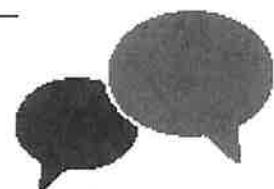
Signos observados por los padres

- Parece estar aturdido o desorientado.
- Se olvida de una instrucción, está confundido sobre su deber o posición, o no está seguro del juego, puntaje u de quién es su oponente.
- Se mueve con torpeza.
- Responde a las preguntas con lentitud.
- Pierde el conocimiento (*aunque sea por poco tiempo*).
- Muestra cambios de ánimo, comportamiento o personalidad.
- No puede recordar eventos *antes* o *después* de un golpe o una caída.

Síntomas reportados por los adolescentes

- Dolor de cabeza o "presión" en la cabeza.
- Náuseas o vómitos.
- Problemas de equilibrio o mareo, o visión borrosa o doble.
- Sensibilidad a la luz o al ruido.
- Se siente débil, desorientado, aturdido o grogui.
- Confusión o problemas de concentración o memoria.
- No se siente "del todo bien" o está "bajoneado".

Hable con los adolescentes sobre las conmociones cerebrales. Pídale que notifiquen sus síntomas de conmoción cerebral de inmediato tanto a usted como al entrenador. Algunos adolescentes piensan que las conmociones cerebrales no son graves o les preocupa que si notifican la conmoción cerebral pueden perder su posición en el equipo o verse débiles. Recuérdeles que es preferible perderse un juego que toda la temporada.



Center for Disease
Control and Prevention
National Center for Injury
Prevention and Control

**LOS BUENOS COMPAÑEROS SABEN QUE:
ES MEJOR PERDERSE UN JUEGO QUE TODA LA TEMPORADA.**

Las conmociones cerebrales afectan a cada adolescente de manera diferente. Mientras que la mayoría de los adolescentes con una conmoción cerebral se sienten mejor después de un par de semanas, algunos tienen síntomas que duran meses o más tiempo. Hable con el proveedor de atención médica de su adolescente si los síntomas no desaparecen o si empeoran después de que regresa a las actividades normales.



Planifique.

¿Qué quiere que su hijo adolescente sepa sobre las conmociones cerebrales?

¿Cuáles son algunos signos de peligro más graves a los que debo prestar atención?

En raras ocasiones, después de un golpe, impacto o sacudida en la cabeza o en el cuerpo puede acumularse sangre (hematoma) de forma peligrosa en el cerebro y ejercer presión contra el cráneo. Llame al 9-1-1 o lleve a su hijo adolescente a la sala de urgencias de inmediato si después de un golpe, impacto o sacudida en la cabeza o el cuerpo, presenta uno o más de estos signos de riesgo:

- Una pupila más grande que la otra.
- Mareo o no puede despertarse.
- Dolor de cabeza persistente y que además empeora.
- Dificultad de dicción, debilidad, entumecimiento o menor coordinación.
- Náuseas o vómitos, convulsiones o ataques (temblores o espasmos) periódicos.
- Comportamiento inusual, mayor confusión, inquietud o nerviosismo.
- Pérdida del conocimiento (desmayado o inconsciente). Incluso una breve pérdida del conocimiento debe considerarse como algo serio.



Usted también puede descargar la aplicación de CDC HEADS UP (en inglés) para obtener información a su alcance sobre las conmociones cerebrales. Simplemente scanee con su teléfono celular inteligente el código QR de la imagen a la izquierda.



Centers for Disease
Control and Prevention
National Center for Injury
Prevention and Control

¿Qué debo hacer si creo que mi hijo adolescente tiene una posible conmoción cerebral?

Como padre, si usted cree que su hijo puede tener una conmoción cerebral, usted debe:

1. Retirarlo del juego.
2. No permitir que regrese a jugar el día de la lesión. Su adolescente debe ver a un proveedor de atención médica y solo podrá regresar a jugar con el permiso de un profesional médico con experiencia en la evaluación de conmociones cerebrales.
3. Pedirle al proveedor de atención médica de su adolescente que le dé instrucciones por escrito sobre cómo ayudarlo a que regrese a la escuela. Usted puede darle indicaciones a la enfermera de la escuela e instrucciones sobre cómo regresar al juego al entrenador o instructor deportivo.

No trate usted mismo de juzgar la gravedad de la lesión. Solo un proveedor de atención médica debe evaluar a un adolescente de una posible conmoción cerebral. Es posible que al principio usted no sepa qué tan grave es la conmoción cerebral y algunos síntomas pueden tardar horas o días en aparecer. El regreso del adolescente a la escuela y los deportes debe ser un proceso gradual manejado y vigilado por un proveedor de atención médica.

Los adolescentes que continúan jugando mientras tienen síntomas de conmoción cerebral o que regresan al juego muy temprano, mientras el cerebro todavía se está curando, tienen mayor probabilidad de tener otra conmoción cerebral. Tener otra conmoción cerebral que ocurra mientras el cerebro todavía se está curando de la primera lesión puede ser muy grave y puede afectar al adolescente de por vida; hasta puede ser mortal.

Febrero del 2016

Para obtener más información, visite:

www.cdc.gov/headsup/youthsports/index-esp.html

ATTENTION PARENTS AND GUARDIANS

Supplemental Student Accident Insurance is Now Available



Health Special Risk, Inc. is offering two options for supplemental student accident insurance.

AT-SCHOOL COVERAGE

At-School coverage provides protection for students enrolled full time in Kindergarten through 12th grade during regular school hours for the entire school year.

24-HOUR COVERAGE

This coverage provides protection 24 hours a day, seven days a week for any covered student accident that occurs anywhere, not just on school grounds.

The premium for either option is paid annually. This one-time payment provides coverage for the entire year. Both coverage options provide protection beginning from the date of enrollment in the plan.

Supplemental student accident insurance is applicable for any covered activity. Certain exclusions and limitations apply. Please read the policy information carefully for an overview of the plan. If you wish to purchase this coverage, here's how to enroll:

Go to: www.K12StudentInsurance.com

New Visitors

- 1 Browse rates
- 2 Open a new account – Once you've determined your school is covered, you'll need to open a new account and add student and coverage
- 3 Add student(s) and coverage on the MyAccount page

Returning Account Holders

- 1 MyAccount Logon
- 2 Maintain Student Data
- 3 Maintain Insurance Coverage

For information or assistance regarding all student insurance, contact our customer service department at (866) 409-5733.

Underwritten by Mutual of Omaha Insurance Company,
3300 Mutual of Omaha Plaza, Omaha, NE 68175.

Policy Form T5MP Series 6440S NC; Series 6754S FL

Policy Form B33MP Series 8408S TX

Policy Form SR2014 TX

Riders: 868MS-EZ, 0KV5M, 6785M, 0CX5M, 867MS-EZ, 6773M, 0KV4M,
1359MS-EZ, 6653M, 850MS-EZ, 851MS-EZ, 6425M Rev 04-10, 0LJ8MS,
9130MS, 6925M, 1364MS, 0LC7M.



HSR
Health Special Risk, Inc.

ATENCIÓN, PADRES Y GUARDIANES

Ahora está disponible el Seguro contra accidentes estudiantiles adicional



Health Special Risk, Inc. ofrece dos opciones de seguro contra accidentes estudiantiles adicional.

COBERTURA EN LA ESCUELA

La cobertura en la escuela brinda cobertura para los estudiantes inscritos tiempo completo en Kindergarten hasta el grado 12 durante el horario normal de escuela para todo el ciclo lectivo.

COBERTURA LAS 24 HORAS

Esta cobertura brinda protección las 24 horas al día, los siete días de la semana, para cualquier accidente estudiantil cubierto que ocurra en cualquier lugar, no solo en el territorio de la escuela.

La prima para cualquiera de las dos opciones se paga anualmente. Este pago único ofrece cobertura para todo el año. Ambas opciones de cobertura ofrecen protección desde la fecha de inscripción en el plan.

El seguro contra accidentes estudiantiles adicional es aplicable a cualquier actividad cubierta. Se aplican ciertas exclusiones y limitaciones. Lea cuidadosamente la información de la póliza para ver una descripción general del plan. Si desea comprar esta cobertura, esta es la forma de inscribirse:

Suscrito por Mutual of Omaha Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175.

La póliza o certificado que afecta la cobertura y los servicios descritos en este aviso se proporciona exclusivamente en inglés. Así mismo, toda la documentación relacionada también se proporcionará exclusivamente en inglés. En caso de adquirir este producto, le recomendamos contactar a un traductor.

Nota: Las pólizas y certificados de aseguramiento se encuentran disponibles en español para los residentes de Puerto Rico, previa petición.

Vaya a: www.K12StudentInsurance.com

Nuevo visitante (New Visitors)

- 1 Buscar tarifas (Browse Rates)
- 2 Abrir una nueva cuenta: una vez que haya determinado que su escuela está cubierta, tendrá que abrir una nueva cuenta, y agregar al estudiante y la cobertura
- 3 Agregar estudiantes y cobertura en la página MyAccount

Titulares de cuenta frecuentes

- 1 Inicio de sesión en MyAccount
- 2 Mantener datos del estudiante
- 3 Mantener la cobertura del seguro

Para información o asistencia sobre todos los seguros del estudiante, póngase en contacto con el departamento de servicio al cliente al (866) 409-5733.



Mutual of Omaha

HSR
Health Special Risk, Inc.



Alcohol, Tobacco, and Other Drug Possession, Use and Abuse Penalties Policy

*The statewide policy every athlete and
athlete's parents should know*

Participation in high school athletics is a
privilege, not a right, and underage drinking
and use of controlled substances is against
the law.

www.niaa.com

THE PENALTIES - KNOW THEM

FREQUENTLY ASKED QUESTIONS

How is an investigation handled?

All investigations and penalty enforcements are conducted by the school and/or district with support through the NIAA office. There is no interrogation of the student, but a question and answer session related to the reported incident.

When does the 14-day suspension begin?

The suspension begins with the first scheduled competition after the suspension occurs and includes Saturdays and Sundays.

Is there an appeal process?

All appeals related to the investigation are handled by the principal of the school the student attends.

1st Violation

A six (6) competitive week suspension from participation in interscholastic competition beginning with the first scheduled competition after the suspension occurs. *Four (4) competitive weeks of the suspension of eligibility may be waived* if a student successfully completes all components of the appropriate substance abuse intervention program. The student may practice with the team during the period of suspension if approved by the coach and principal.

2nd Violation

The student shall be suspended from interscholastic competition for a minimum of ninety (90) school days which shall include a minimum of six (6) competitive weeks of competition. The student shall not be allowed to practice with the team, or participate in any out of season activities and must complete the following requirements:

- A. A substance abuse evaluation assessment within ten (10) school days following the suspension, with all recommendations satisfactorily met before eligibility may be reinstated.

3rd Violation

The student shall be ineligible to participate in interscholastic athletics for the remainder of the student's high school career.

This regulation takes effect once the student begins participation as an athlete in high school. This policy remains in effect for every calendar school year during the course of the student's high school career and when the student is directly involved in a school activity occurring at any time (summer leagues, camps, etc.) This policy remains in effect regardless of whether the student is currently participating on a high school athletic team.

The same things that makes these athletes excel - a certain amount of risk-taking - may be the same things that increase their vulnerability to substance use.

- Dr. Shashank Joshi
Stanford University

NEVADA LAW - KNOW IT

NRS 202.020: Purchase, consumption or possession of alcoholic beverage by minor.

1. Any person under 21 years of age who purchases any alcoholic beverage or any such person who consumes any alcoholic beverage in any saloon, resort or premises where spirituous, malt or fermented liquors or wines are sold is guilty of a misdemeanor.
2. Any person under 21 years of age who, for any reason, possesses any alcoholic beverage in public is guilty of a misdemeanor.
3. This section does not preclude a local government entity from enacting by ordinance an additional or broader restriction.
4. For the purpose of this section, possession "in public" includes possession a) on any street or highway; b) in any place open to the public; and c) in any private business establishment which is in effect open to the public.





Aktivate

Instructions For Parents

Register My Athlete allows parents to register their athletes for sports online. Here are some basic steps to follow when registering your athlete for the first time:

1. **Find Your School:** Find your school by going to <http://registermyschool.com/schools/>, selecting Nevada and finding your school. Click on the school to continue to the next step. Schools are encouraged to make a direct link from their school's website.
2. **Create an account:** Now begin creating your account by clicking the "Create An Account" button. After filling in the required information the system will automatically log you in and you will be required to accept the terms of use.
3. **Add a new athlete:** The next step is to add an athlete. You can do so by clicking the "My Athletes" tab on the left-hand side of the page or by clicking "Add Athlete" underneath the "My Athletes" tab. The only needs to be done once during your athlete's entire career at a school. The information entered here will carry over from year to year. This information includes your athlete's contact information and medical information.
4. **The athlete's profile:** After you've created your athlete you will be brought to their Profile page. This page is a summary of their info and involvement.
5. **Register for a sport:** Click "+Register For A Sport" to begin registration, you will be asked to choose which sport your athlete is registering for.
6. **Your registration checklist:** This page shows the status of your athlete's registration. You will be asked to complete several steps to complete registration including agreeing to documents, and completing the physical.
7. **Physicals:** Physical documents should be completed by the parents (or medical medical professionals as needed). Parents have the ability to upload these physical documents to the system. Uploaded documents will need to be verified by the admin at the school prior to be accepted as complete. (If a document upload is rejected for any reason, the parent will receive an email with the rejection reason. After the error has been corrected, parents will be able to re-upload the document for verification.)
8. **Complete registration:** Your registration is complete once all items on the checklist have been completed.
9. **After registration:** After registration is complete, you can login at any time to view the status of your athlete and their participation on the team.

Additional Athletes

Under the same account, repeat steps 3-9 to register additional athletes

Future Seasons & Years

Once your athlete has been added to your account, you only need to follow steps 5-8 to register them for another sport.



COMPLETE THIS FORM AND SUBMIT IT TO:

KIDS FOR SPORTS FOUNDATION

403 PARADISE PKWY, MESQUITE, NV 89027

FOR MORE INFORMATION CALL:

Maria Garcia: (702) 346-1670

kidsforsportsfoundation@gmail.com

Kids for Sports ensures all kids are given the opportunity to experience the positive benefits of playing organized sports. We do this by helping remove financial and other barriers that prevent kids from participating in sports.

~This application is only for families with children that would not otherwise be able to play a sport~

Application for Financial Assistance

Eligibility

To be eligible for assistance, a child must meet each of the criteria listed below:

- Live in Virgin Valley Area (Mesquite, Beaver Dam, Bunkerville & Scenic)
- Be enrolled in school (Pre-K through 12th grade)
- Commit to attend a minimum of 80% of scheduled practices and games
- Not be currently enrolled in an existing fee waiver program
- Grant limits per current fiscal year (July 1 to June 30)
 - Up to \$200 per child per year
- Grants awarded to KFS approved list of sports.

Requester First Name: _____ Parent Name: _____

Requester Last Name: _____ Coach Name: _____

Street Address: _____ City, State, and Zip: _____

Daytime Phone: _____ Evening or Cell Phone: _____

E-Mail Address: _____

Age: _____ Gender: _____ Date of Birth: _____ School: _____ Grade: _____

• Which sport is your child requesting to play & where? _____ Which season & team? _____

• Which type of assistance are you requesting? Please select choice:

For FC Mesquite Applicants:

Has child played club soccer before? Yes ☐ No ☐

☐ Registration Fee Waiver ☐ Equipment/Uniform Voucher ☐ Travel ☐ Other: _____

• Dollar amount requested \$ _____ What is your deadline for assistance? _____

• Are parents/guardian currently employed: Yes / No (circle one). Are you a 1 or 2 income household: _____

• PARENTS - please explain why you are requesting financial assistance in detail (what is your current hardship): _____

• CHILD/ATHLETE - please explain why you want to play this sport (In child's own hand writing please): _____

CONSENT TO EXCHANGE INFORMATION: I understand that information may be needed to verify eligibility for this program and to coordinate services with other agencies; therefore, I agree that agencies may share my child's information. I certify that the information supplied is true and correct and that Kids for Sports Foundation staff have my permission to verify the information on this application. Kids for Sports Foundation reserves the rights to determine and prioritize needs. I understand that my child's participation in this program requires a commitment to attend a minimum of 80% of the scheduled practices and games. I also understand my child's picture may be taken for publicity purposes.

Signature of Applicant: _____ Date: _____

* Grant requests for camps will be considered for a target of 75%.

* Late registration fees will not be awarded on grants.

* Grant applications will not be accepted for reimbursements.

Revised: March 17, 2022

