YERINGTON INTERMEDIATE SCHOOL

ATHLETIC PARTICIPATION

ALL ATHLETES MUST COMPLETE THE FOLLOWING PRIOR TO PARTICIPATION IN ANY TRYOUT OR PRACTICE.

1. **PHYSICAL** (USE NIAA FORM) (ATTACHED)
   Required before participation in any tryout or practice.
   One physical covers athletes for grades 5–8 at YIS.

2. **COMPLETE LYON COUNTY SCHOOL DISTRICT ATHLETE REGISTRATION FORM** (COACHES WILL PASS OUT)

3. **COMPLETE HEAD INJURY FORM ACKNOWLEDGMENT** (COACHES WILL PASS OUT)

4. **COMPLETE EXTRA AND CO-CURRICULAR EXPECTATIONS ACKNOWLEDGMENT**
   (COACHES WILL PASS OUT)

IMPORTANT UPDATE FOR 2026–2027:
All athletes participating in sports MUST have a physical on file prior to tryouts and practice.

IF QUESTIONS, PLEASE CONTACT:
Miss Sciarani at 463-6833
or email at asciarani@lyoncsd.org

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 *Staphylococcus aureus* (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.

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	Sí	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 inexplicables)?		
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	**Sí**	**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	**Sí**	**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 meticilina (MRSA)?		

PREGUNTAS SOBRE CONDICIONES MÉDICAS (*CONTINUACIÓN*)	Sí	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	**Sí**	**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 "Sí".

_____

_____

_____

_____

_____

_____

_____

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

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, 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?
2. 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[a] • 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		

* 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).

a 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 Per Patient History (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: _____

Lyon County School District
Student Athlete
Registration Form
2026-2027

REGISTRATION INFORMATION

Student #: _____

First Name _____

Last Name _____

NAME: _____ GRADE: _____ AGE: _____ GENDER: M F D.O.B.:_____

RESIDENCE ADDRESS: _____

MAILING ADDRESS: If different:_____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: (H)_____ (C)_____

MOTHER'S NAME: _____ FATHER'S NAME:_____

LIVES WITH: BOTH PARENTS ☐ MOTHER ONLY ☐ FATHER ONLY ☐ OTHER: Please list: ☐

_____

CIRCLE SPORTS INTERESTED IN PARTICIPATING IN

Baseball	Basketball	Cheer	Cross Country	Dance	Football
Golf	Soccer	Softball	Swimming	Track	Volleyball
Wrestling					

HEALTH INSURANCE INFORMATION—MANDATORY
ATHLETICS INSURANCE WAIVER - STUDENT

I certify that the above named student has full health and accident coverage with :
_____, *Address:* _____
Name of Carrier

Policy #: _____ *Expiration Date of Policy:* _____

This policy covers any and all accidents and injuries that may be sustained while engaging in any extracurricular athletic activity. In the event of cancellation of the above policy or substitution of the policy, I will immediately notify the school principal of such action.

EMERGENCY CONTACT INFORMATION

	Home Phone	Business Phone	Cell Phone
FATHER:	_____	_____	_____
MOTHER:	_____	_____	_____

EMERGENCY CONTACT PERSON(S): _____
Name Phone

EMERGENCY TRANSPORTATION APPROVAL

This is to certify that (I/we), the parents of the above named student give full permission to Lyon County coaches, trainers, or administrators, at practice or at actual athletic events, in town or out of town, to call an ambulance service or otherwise provide emergency transportation to a hospital for medical treatment.

(I/We) understand that every effort will be made to contact parents immediately, but should there be difficulty, (I/we) will not hold any Lyon County School District representative responsible for any costs or liabilities associated with such actions.
EMERGENCY TRANSPORTATION BY SCHOOL:_____ YES _____ NO
Please indicate in the space below if your child has any allergies or needs special attention,

_____

In the event that the above named student should need emergency medical treatment or attention while under the care of athletic or school personnel, necessary treatment may be secured. I give LCSD permission to treat my child. The school shall not be held responsible for any debts incurred.

_____
PARENT SIGNATURE REQUIRED FOR PERMISSION TO TREAT

FORM B -- NIAA PRE-PARTICIPATION HISTORY FORM

EXPLAIN "YES" ANSWERS BELOW.
CIRCLE QUESTIONS YOU DON'T KNOW THE ANSWERS TO.

	YES	NO
1. Do you have a chronic medical condition (asthma, diabetes, high blood pressure, etc.)?	☐	☐
2. Have you ever been hospitalized overnight?	☐	☐
3. Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler?	☐	☐
4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insect)?	☐	☐
5. a. Have you passed out or been dizzy during exercise?	☐	☐
b. Have you had chest pain (or pressure) with exercise?	☐	☐
c. Have you had excessive unexplained shortness of breath or fatigue with exercise?	☐	☐
d. Is there a family history of premature death or morbidity from cardiovascular disease in a relative younger than age 50?	☐	☐
e. Is there any history in your family of hypertrophic cardiomyopathy, dilated cardiomyopathy long QT syndrome or Marfan's syndrome?	☐	☐
f. Has a physician denied or restricted your participation in sports for any heart problem?	☐	☐
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)?	☐	☐
7. a. Have you had a head injury or concussion?	☐	☐
b. Have you been knocked out, become unconscious, or lost your memory?	☐	☐
c. Have you had a seizure?	☐	☐
d. Do you have frequent or severe headaches?	☐	☐
e. Have you had numbness or tingling in your arms, hands, legs, or feet?	☐	☐
8. Have you become ill from exercising in the heat?	☐	☐
9. Do you cough, wheeze, or have trouble breathing during or after activity?	☐	☐
10. a. 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)?	☐	☐
b. Are you missing an eye, kidney, testicle or ovary?	☐	☐
11. a. Have you had any problems with your eyes or vision?	☐	☐
b. Do you wear glasses, contacts, or protective eyewear?	☐	☐
12. a. Have you had any problems with pain or swelling in muscles, tendons, bones, or joints?	☐	☐

b. If yes, check appropriate item and explain below.

☐ Head	☐ Elbow	☐ Hip	☐ Neck	☐ Forearm	☐ Thigh
☐ Back	☐ Wrist	☐ Knee	☐ Chest	☐ Hand	☐ Shin/Calf
☐ Shoulder	☐ Finger(s)	☐ Ankle	☐ Upper Arm	☐ Foot	☐ Toe(s)

13. Are you actively trying to gain or lose weight?	☐	☐
14. Would you like to talk to someone about stress, anger, depression or other issues?	☐	☐

15. Record the dates of your most recent immunizations (shots) for:

Tetanus _____ Measles _____ Hepatitis B _____ Chickenpox _____

FEMALES ONLY

16. 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? _____

EXPLAIN "YES" ANSWERS HERE: _____

- ✓ Insurance Information
- ✓ Impact/Concussion Management
- ✓ Field Trip Permit & Media Release
- ✓ NIAA & LCSD Residency Statement

Hold Harmless Agreement
Emergency Transportation
NIAA Alcohol, tobacco, drug policy
Guidelines/Expectations of parents & athletes.

PARENT/LEGAL GUARDIAN AND STUDENT ACKNOWLEDGEMENT

The Nevada Interscholastic Activities Association (NIAA) recognizes and understands that parents / guardians take the primary role in instilling values for their students. It is the goal of the NIAA to work cooperatively with parents to provide guidelines and programs that assist student athletes in making positive choices.

IMPORTANT – Please read the following information and acknowledge with your signature below.

We understand that participation in high school athletics is a privilege, not a right, and that underage drinking and drug use is against the law. It is against the law to sell tobacco to people under the age of 18 and usage is against school policy. Substance abuse negatively impacts athletics and academic performance, and research indicates that early onset of alcohol use increases the occurrence of addiction in adulthood by four times. Alcohol and drug use interferes in learning processes, brain development and increases the chance of physical injury while participating in athletic competition. Because of these risks, and in addition to the laws of the State of Nevada, the NIAA requires participants and parents to agree to the following:

1. We have read the NIAA Drug, Alcohol and Tobacco Possession, Use and Abuse Penalties Policy and agree to abide by the Policy as written.
2. We realize that a Power Point presentation regarding the Policy is available and we have either seen this presentation or agree to waive the requirement of viewing the presentation.
3. ***We understand that we are encouraged to notify our school's athletic administrator / director if our son / daughter violates this Policy and / or the laws of the state of Nevada. It would also be acceptable for our child to self-report any violation of this policy to our school's athletic administrator / director.***
4. ***We understand that knowingly providing erroneous information during the course of an investigation of an alleged violation of the policy will result in a one calendar year suspension from all high school athletic activities.***
5. ***We further acknowledge that once our son / daughter begins participation as a student athlete in high school athletics that this policy remains in effect for every calendar school year during the course of their high school career and when he / she is directly involved in a school activity occurring at any time (summer leagues / camps, etc.). This policy remains in effect regardless of whether our son / daughter is currently participating on a high school athletic team.***
6. ***We have also reviewed the following NRS 202.020, Purchase, Consumption or Possession of Alcoholic Beverage by Minor, and understand the laws of Nevada and how they pertain to our family.***
7. ***We understand that although it is not technically against the law to use tobacco in the state of Nevada (NRS 202.2493 and 202.24935 prohibits anyone from supplying a person under the age of 18 with any kind of tobacco product), we realize it is against this policy and general school policy, and that scientific evidence demonstrates it is unhealthy and a detriment to athletic performance.***
8. ***We understand that the use of steroids and other performance enhancing drugs are dangerous, illegal, provide only temporary gains and are a form of cheating other competitors.***

NEVADA LAW

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.
5. **This term does not include:**
   a. Possession for an established religious purpose;
   b. Possession in the presence of the person's parent, spouse or legal guardian who is 21 years of age or older;
   c. Possession in accordance with prescription issued by a person statutorily authorized to issue prescriptions;
   d. Possession in private clubs or private establishments; or
   e. The selling, handling, serving or transporting of alcoholic beverages by a person in the course of his lawful employment by a licensed manufacturer, wholesaler or retailer of alcoholic beverages.

[1:272:1947; 1943 NCL § 10594.02] – (NRS A 1967, 482; 1987, 482)

Your signature on this page indicates you have read, understand and agree with <u>all</u> of the information contained within this packet. Also, that to the best of your knowledge, the information contained within this document is complete and accurate.

_____
Student Signature
Date _____

_____
Parent/Guardian Signature
Date _____

Residency/Custody Statement and Information

SECTION 5

Are you attending this High School on a Zone Variance: ☐ Yes ☐ No

Date entered this High School: _____ (Month & Year)

Date entered ninth (9TH) grade: _____ (Month & Year) Age: _____ (When entered 9th)

Last school attended: (MS or HS) _____

Please answer the following questions:

1. Is your son/daughter transferring from another school (including Junior High/Middle School)? Yes No
   If yes, name of school: _____
   If the above school was a Junior High or Middle School and you were to have remained at this school, what high school would you have attended: _____
2. Was your son/daughter or any member of your family recruited by any member of the faculty or coaching staff for the purpose of participation in athletics at this High School? Yes No

Parent Initials	*Student Initials*
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

RESIDENCY: We understand this student must reside with a parent in the attendance zone of this high school. 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.
RESIDENTIAL AFFIDAVIT: We understand that if we are living with someone else on a residential affidavit, the student is ineligible for high school athletics and an appeal must be submitted to be considered for athletic eligibility.
TRANSFERS: We understand that if a student transfers from a private to a public school or from a magnet school he/she is ineligible for varsity athletics.
ZONE VARIANCE: We understand that if a student is enrolled on a zone variance he/she is ineligible for varsity athletics until they are an established student after 180 school days, per the NIAA.
GUARDIANSHIP: We understand that notarized guardianships and parent appointed guardianships are not accepted for athletic eligibility.
We understand a legal guardian must be court appointed by a judge **in accordance with NAC 386.785 (Sec. 3a-b), and an appeal must be submitted** to be considered for athletic eligibility
SEPARATED PARENTS: We understand that if a parent or guardian is separated, the student's athletic eligibility will remain at the current school of enrollment.
DIVORCED PARENTS: We understand that if a parent or guardian is divorced, the student's athletic eligibility is in the zone of the primary custodial parent or remains at the current school of enrollment.
FALSE DOCUMENTATION: 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 any events in which this student was a participant. **Forfeiture of games has a serious effect on all members of a team. Finals standings are impacted and league, region and state championships may be lost.**

FIELD TRIP PERMIT

I request that my child be allowed to participate in an authorized Lyon County School District Field Trip. I understand that my child will be chaperoned by a responsible adult while away from the school, who will take reasonable precautions to protect my child from harm and injury.

I understand that this is a supervised activity. In order to maintain order, students will be expected to comply with rules, standards; and instructions for student behavior. I waive and release all claims against Lyon County School District employees or their agents arising out of my child's failure to remain under such supervision. If at any time my child's behavior is incompatible with the standard for student behavior, his/her further participation may not be permitted.

In the event that my child is injured, becomes ill or involved in an accident while away, I understand that the chaperon will seek medical attention for my child, and the school will contact me as soon as possible, and that I will be financially responsible for medical treatment. I further agree to hold the Lyon County School District, its employees, and agents harmless for any injury or illness caused by the negligence of persons other than employees or agents of the Lyon County School District when such injury illness occurs during the trip.

Please note any medical information which would be of help: (i.e., allergies, medications to avoid, current medications, etc.)

_____

_____

☐ Initial inside of this box if you <u>do not</u> wish your child to take part in school field trips. If you initial this box, your child will not be able to participate in athletics.

<u>WARNING, AGREEMENT TO OBEY INSTRUCTIONS, RELEASE, ASSUMPTION OF RISK, AND AGREEMENT TO HOLD HARMLESS</u>

As a student and/or parent/legal guardian I/we are aware that playing or practicing to play/participate in any sport can be dangerous in nature involving **MANY RISKS OF INJURY.** I/We understand that the dangers and risks of participating in sports includes, but is not limited to, death, serious neck and spinal injuries which may result in partial paralysis, brain damage, serious injury to all bones, joints, ligaments, muscles, tendons, and other aspects of the muscular skeletal system, serious injury to all internal organs, and serious injury or impairment of other aspects of my body, general health and well-being. I/We understand that the dangers and risks may result not only in serious Injury, but in a serious Impairment of future abilities to earn a living, to engage in other business, social and recreational activities and generally to enjoy life.

Because of the dangers of participating in sports, I/we recognize the importance of following coaches' instructions regarding playing techniques, training and other team rules, etc. and do agree to obey such instructions.

In consideration of the Lyon County School District permitting this student to try out for the school teams indicated and to engage in all activities related to the team, including, but not limited to, trying out, practicing or playing/participating in that sport, I/we hereby assume all the risks associated with participation and agree to hold the Lyon County School District, its employees, agents, representatives, coaches and volunteers harmless from any and all liability, actions, causes of action, debts, claims or demands of any kind and nature whatsoever which may arise by or in connections with participation in any activities related to the high school athletic teams. The terms hereof shall serve as a release and assumption of risk for heirs, estate, executor, administrator, assignees and for all members of the family.

Your signature below indicates that you acknowledge that football, soccer, wrestling, baseball, softball and pole vaulting are violent contact sports that involve even greater risk of injury than other sports. It also indicates that you have read and understand the risks as detailed in this agreement.

I ☐ ***give permission*** ☐ ***do not give permission,*** as the student/athlete and/or parent/guardian of this student for the Lyon County School District to release the name, photograph and/or audio/video/film reproduction for publication, broadcast or posting to the LCSD.net website

I have read and understand the rules and regulations set forth in the Student Handbook and attest that to the best of my knowledge and ability I have conformed to all rules and regulations of the Nevada Interscholastic Activities Association and the Lyon County School District.

As the parent/guardian, I understand that my son/daughter will be covered by the Impact Concussion Management Program. My signature gives permission for exchange of all necessary information among school staff (trainers, coaches, athletic director, nurses, teachers, administrators, etc) Sports Concussion Specialists of Nevada - Dr.'s Kinsora and Ross, your child's health provider, and you the parent/guardian to assist with decisions regarding clearance for your child to resume participation and/or competition.

Parent/Guardian_____ **Date**_____

Student Athlete_____ **Date**_____

YIS

STUDENT ATHLETE SAFETY

HEAD INJURY & CONCUSSION POLICY

IF A STUDENT HAS OR IS SUSPECTED OF HAVING A CONCUSSION:

REMOVED FROM PLAY IMMEDIATELY.

The student will be removed from play right away.

NO RETURN TO PLAY THE SAME DAY.

The student may NOT return to sports or activities the same day.

MEDICAL CLEARANCE REQUIRED.

A healthcare provider must give written medical clearance before return.

PARENTS NOTIFIED & POLICY PROVIDED.

Parents/guardians will be notified and provided the district policy.

WHY IT MATTERS:

A concussion is a brain injury. Returning to activity too soon can increase the risk of serious injury and delay recovery.

WHEN IN DOUBT, SIT THEM OUT.

PARENTS & STUDENTS

Before participating in athletics:

- **Review** the Head Injury & Concussion Policy
- **Know** the signs and symptoms of a concussion
- **Follow** all return-to-play requirements if an injury occurs

SCAN HERE FOR THE FULL POLICY

Policy JB: Prevention & Treatment of Injuries to the Head

YERINGTON INTERMEDIATE SCHOOL ATHLETICS

Protect their future. Support their game.

LYON COUNTY SCHOOL DISTRICT

BOARD POLICY_____JB

Acknowledgement and Signatures

Parent/Guardian Acknowledgement: I _____ have read the Lyon CSD Board Policy JB: Prevention and Treatment of Injuries to the Head and the CDC's parent/guardian fact sheet. I understand all the aspects of the policy including, but not limited to the notice, warning, school responsibilities, and my responsibilities. I agree to comply with the policy.

Parent/Guardian
Signature_____Date_____

Student Acknowledgement: I_____ have read the Lyon CSD Board Policy JB: Prevention and Treatment of Injuries to the Head and the CDC's handout. I understand all the aspects of the policy including, but not limited to the notice, warning, school responsibilities, and my responsibilities. I agree to comply with the policy and follow the instructions of my coach/advisor as I participate in the LCSD sport and/or activity.

Student Signature_____Date_____

Policy JB
Adopted 07/23/24

YERINGTON INTERMEDIATE SCHOOL

EXTRA & CO-CURRICULAR EXPECTATIONS

FOR PARENTS & GUARDIANS

At Yerington Intermediate School, we believe participation in extra and co-curricular activities is a privilege that supports student growth, teamwork, and school pride.

KEY EXPECTATIONS

ACADEMIC ELIGIBILITY
Students must maintain passing grades and meet academic standards to participate.

RESPECT & CONDUCT
Positive behavior, respect for others, and good sportsmanship are expected at all times.

ATTENDANCE MATTERS
Students must be in school on the day of activities to be eligible to participate.

COMMITMENT
Students are expected to attend all practices, meetings, and events unless pre-approved.

FOLLOW THE RULES
Students must follow school, team, and district rules and policies.

WANT TO READ THE FULL POLICY?

Scan the QR code below to view the complete policy.

THANK YOU FOR SUPPORTING OUR STUDENTS AND HELPING THEM REPRESENT YIS WITH PRIDE!

TOGETHER, WE ARE YIS.

LYON COUNTY SCHOOL DISTRICT
BOARD POLICY _____IGDC

I have read and agree to abide by the rules and regulations in order to participate in the designated student extra-/co-curricular activity.

Activity: _____ School Year:_____

_____	_____	_____
Student Printed Name	**Parent/Guardian Printed Name**	**Date**
_____	_____	_____
Student Signature	**Parent/Guardian Signature**	**Date**