

CONSENT TO PERFORM RANDOM DRUG TESTING

Student Name _____ Grade _____

As a student and parent:

- We understand and agree that participation in extracurricular activities is a privilege that may be withdrawn for violations of the Extracurricular Drug Testing Policy.
- We have read the Extracurricular Drug Testing Policy and understand the responsibilities and consequences as an activity participant if the student violates the policy.
- We understand that when students participate in any extracurricular activity, they will be subjected to random drug testing, and if they refuse, will not be allowed to practice or participate in any extracurricular activity. We have read this consent statement and agree to its terms.
- We understand this is binding while a student is enrolled at Northwest High School.

CONSENT TO PERFORM DRUG TESTING

We hereby consent to allow the student named on this form to undergo drug testing for the presence of drugs and alcohol in accordance with the Extracurricular Drug testing Program adopted by the Board of Education. We understand that any samples will be sent only to a qualified laboratory for actual testing. We hereby give our consent to the medical vendor selected by the school board, their Medical Review Officer (MRO), laboratory, doctors, employees, or agents, together with any clinic, hospital, or laboratory designated by the selected medical vendor to perform testing for the detection of drugs and to release the results of those tests as provided in the policy. We understand these results will be forwarded to school district officials and will also be made available to us. We agree to sign any necessary release if requested to do so.

We understand that consent pursuant to this Consent to Perform Random Drug Testing will be effective for all extracurricular activities in which this student might participate during the current school year.

We hereby release the Northwest Public Schools Board of Education and its employees from any legal responsibility or liability for the release of such information and records, pursuant to the policy.

Student Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

NORTHWEST HIGH SCHOOL DISTRICT #82 AUTHORIZATION FOR ATHLETIC PARTICIPATION

SPORTS CANDIDATE'S QUESTIONNAIRE

(To be completed by parents)

(PLEASE PRINT)
 STUDENT NAME (Last, First, M.I.) _____
 BIRTHDATE _____ GRADE ENTERING (circle) 6 7 8 9 10 11 12
 ADDRESS _____ PHONE _____
 CITY _____ STATE _____ ZIP _____
 NAME OF PARENT/LEGAL GUARDIAN _____
 FAMILY PHYSICIAN'S NAME _____ PHONE _____

PROCEDURE OF DUE PROCESS OF NORTHWEST HIGH SCHOOL DISTRICT #82

"Due Process" is a procedure which the courts of law recognize as a necessary part of any rules and regulations. Due process furthermore, and of importance, recognizes the rights of the individual since it outlines his/her recourse in the event he/she feels a wrong decision has been made. The student Grievance Procedure outlined in the current student handbook is the procedure for an athlete and his/her parents to follow in appealing decisions relating to eligibility. It should be understood that athletes and parents/guardians will be expected to follow the procedure in the event legal action should be initiated at some later date.

I have read the foregoing statements pertaining to "Due Process" and do hereby acknowledge, agree and understand the purpose and content.

Student's Signature _____ Parent/Guardian's Signature _____

ATHLETIC INSURANCE WAIVER

I fully understand that the Northwest High School District #82 does not provide any accidental or health insurance coverage for my son/daughter while participating in interscholastic athletics. I fully understand that it is my/our responsibility to provide or waive the right for insurance coverage.

Parent/Guardian Signature _____ Date _____

A parent/legal guardian may elect to enroll the participant in a supplement insurance program offered by an insurance company authorized by Northwest High School District #82. If you choose to purchase coverage through this plan, check mark line below and contact the Activities Director for additional information. _____

**THIS FORM MUST BE ON FILE IN THE ACTIVITIES OFFICE BEFORE
ATTENDING THE FIRST ATHLETIC PRACTICE**

1. History of diabetes in family..... YES NO
2. History of epilepsy or other seizure disorders..... YES NO
3. Has had injuries requiring medical attention..... YES NO
4. Has had illness lasting more than a week..... YES NO
5. Is under physicians care now..... YES NO
6. Takes medication now..... YES NO
7. Wears glasses..... YES NO
8. Has had a surgical operation..... YES NO
9. Has been in hospital (except of tonsillectomy)..... YES NO
10. Do you know of any reason why this individual should not participate in all sports?..... YES NO
11. Has had complete poliomyelitis immunization by inoculations (Salk) or oral vaccine (Sabin)..... YES NO
12. Most recent tetanus toxoid immunization (Date)..... YES NO
13. Was this a booster?..... YES NO
13. Has seen a dentist within the past 6 months..... YES NO

PARENT/GUARDIAN SIGNATURE _____

HEALTH EXAMINATION FORM

Name of Student _____ City & School _____
 Grade _____ Age _____ Height _____ Weight _____ Blood Pressure _____
 Significant Past Illness or Injury _____
 Eyes R 20/ _____ L 20/ _____ Ears _____ Hearing R _____ /15; L _____ /15
 Respiratory _____
 Cardiovascular _____
 Liver _____ Spleen _____
 Musculoskeletal _____ Skin _____ Hernia _____
 Neurological _____ Genitalia _____
 Laboratory: Urinalysis _____ Other _____
 Comments _____
 Completed Immunizations: Polio (Date) _____ Tetanus (Date) _____
 Other _____

I certify that I am qualified to conduct all phases of the health examination of the above-named student. I further certify that I have on this date examined the student and, on the basis of examination requested by the school authorities and the student's medical history as furnished to me, have for no reason that would make it medically inadvisable for this student to compete in supervised athletic activities, EXCEPT THOSE CROSS OUT BELOW.

- OTHERS
- | | | | | | | |
|----------|----------|---------------|------------|-----------------|-----------|-------|
| Baseball | Golf | Tennis | Basketball | Swimming/Diving | Softball | Cheer |
| Track | Football | Cross Country | Soccer | Volleyball | Wrestling | Dance |

*Estimated Desirable Weight Level _____ Pounds _____
 Date of Examination _____ Examiner's Signature _____
 Examiner's Address _____ Phone _____

NORTHWEST HIGH SCHOOL
EMERGENCY MEDICAL AUTHORIZATION FORM
(Please print legibly)

STUDENT'S NAME: _____ BIRTHDATE: _____

ADDRESS: _____ GRADUATION YEAR: _____

HOME PHONE: _____ CELL PHONE: _____

ACTIVITY (choose all that apply)

<input type="checkbox"/> Football	<input type="checkbox"/> X Country	<input type="checkbox"/> Music	<input type="checkbox"/> Speech	<input type="checkbox"/> FBLA
<input type="checkbox"/> Volleyball	<input type="checkbox"/> Basketball	<input type="checkbox"/> HS Quiz Bowl	<input type="checkbox"/> Drama	<input type="checkbox"/> FFA
<input type="checkbox"/> Softball	<input type="checkbox"/> Wrestling	<input type="checkbox"/> Spirit Squad	<input type="checkbox"/> Field Trips	<input type="checkbox"/> Journalism
<input type="checkbox"/> Soccer	<input type="checkbox"/> Golf	<input type="checkbox"/> Baseball	<input type="checkbox"/> Tennis	<input type="checkbox"/> Swimming
<input type="checkbox"/> Track	<input type="checkbox"/> Student Manager	<input type="checkbox"/> Student Trainer		

EMERGENCY CONTACT:

PARENT OR GUARDIAN: _____ Home Phone _____

Address _____ Cell Phone _____ Work Phone _____

NON-HOUSEHOLD CONTACT: _____ Home Phone _____

Address _____ Cell Phone _____ Work Phone _____

Relationship to Athlete: _____

INSURANCE COMPANY: _____ POLICY #: _____

PHYSICIAN'S NAME: _____ PHONE #: _____

Any known allergies? _____ List: _____

Do you have any of the following medical conditions?

Asthma Kidney Injury Diabetes Epilepsy
 Heart Condition Other (Please specify) _____

Are you currently taking any medications? _____ If yes, please list: _____

Do you wear any of the following?

Glasses Contact Lenses Dental appliances of any kind
 Other (please specify) _____

In the event the designated preferred practitioner is not available, we authorize another licensed physician or dentist the authority and power to render care in his/her best judgment and the transfer of the child to any hospital reasonably accessible. It is also understood that every effort shall be made to contact the parent/legal guardian prior to rendering treatment to the patient, but treatment will not be withheld if the parent/guardian cannot be contacted. Permission is also granted for the school's athletic trainer or coach to provide emergency treatment to my/our child prior to his/her admission to any medical facility.

Signature of Parent/Guardian Date _____