

Participation in extra-curricular activities is a privilege. Students are expected to conduct themselves in an appropriate manner both on and off campus.

#### Initial Eligibility

To be considered eligible to participate in any extra-curricular activity, a student must have:

- A term GPA of 2.0
- No failing grades in the preceding grading period. *The only exception is failing grades in the final grading period of the year may be made up for eligibility purposes in the summer prior to the new school year by approved school methods.*
- Students may tryout but cannot practice or play until the ineligible term has concluded.
- Health and accident insurance (physical examination by a medical doctor is required).
- Payment of all fees (waivers where applicable).
- A minimum of 4 classes/courses at the school (excluding released time).

These regulations also apply to students who are entering high school for the first time.

#### Concurrent Enrollment

- *Concurrent Enrollment grades in relation to eligibility only apply to final grades.*

#### Eligibility During Grading Terms

- Students must maintain grades of D- or higher in high school course work excluding Concurrent Enrollment.
- Compliance with the school's attendance policy.
- *During the grading term, students can practice, but not play or perform until the infraction has been cleared by the teacher and principal.*

#### Safe School Policy Violation

In accordance with the Safe School Policy, students who are suspended or expelled are not allowed to participate in any practice, meet, match, competition or performance during the period of the suspension or expulsion.

#### Drugs, Alcohol, Tobacco and Illegal Behavior

Limitation for participation of students regarding the use of alcohol, tobacco products and other drugs during a sports season, or participating in illegal conduct, whether prosecuted or not, on or off campus:

- First Offense: A two week (14 day) suspension by the coach from games, meets, matches, competitions or performances. Practice may continue.
- Second Offense: A six week (42 day) suspension by the coach from games, meets, matches, competitions or performances. Practice may continue.\*
- Third Offense: An eighteen week (126 day) suspension by the coach from all games, meets, matches, competitions, performances and practices.

\*For drugs, alcohol and tobacco offenses, practice may continue following a personal assessment of the student by a licensed substance abuse intervention or treatment program and/or participation in a district approved intervention program. Reinstatement at the end of any suspension is predicated upon successful participation in an intervention program. Costs related to licensed substance abuse intervention or treatment is the responsibility of the student's parent or guardian.

## STUDENT ACTIVITIES

FFD

### KCSD ACTIVITY AGREEMENT / CODE OF CONDUCT

#### No Fresh Start

Violations carry over year to year and sport/activity to sport/activity in a participant's career (there is no "fresh start" each year). Violations must occur and be discovered during a sport/activity season. Any violation beyond the third offense carries the same penalty as the third offense.

#### Appearance

Students that participate in extra-curricular activities are required to dress at a higher level on game/activity/competition days than on regular school days. Extreme hair styles, extreme make up and untrimmed facial hair is not allowed.

#### Other Guidelines

Any other guidelines imposed by a coach or advisor must have the support of team/activity members, the principal and the school community council and be written and attached to this Code of Conduct form.

#### Due Process

Students and parents will be notified, in writing, of all conditions regarding suspension. Students and parents have the right to appeal to the school principal in writing within 15 days of any decision. An appeal of the principal's decision is directed to the Superintendent. An appeal of the Superintendent's decision is directed to the Kane Board of Education.

#### Permission to Exceed District Policy

Schools within the District may have standards which exceed this policy if approved by the School Board, School Administrator and Community Councils.

I have read and understand this code of conduct and acknowledge that it applies to involvement in extracurricular activities during the season of play. I agree to follow all terms, conditions and consequences.

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

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

though they are acting or feeling differently.

See [Getting Better \(/concussion/feel\\_better.html\)](/concussion/feel_better.html), for tips to help aid your recovery after a concussion.

## When to Seek Immediate Medical Attention:

### Danger Signs in Adults

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. Contact your health care professional or emergency department right away if you have any of the following danger signs after a bump, blow, or jolt to the head or body:

- Headache that gets worse and does not go away.
- Weakness, numbness or decreased coordination.
- Repeated vomiting or nausea.
- Slurred speech.

The people checking on you should take you to an emergency department right away if you:

- Look very drowsy or cannot be awakened.
- Have one pupil (the black part in the middle of the eye) larger than the other.
- Have convulsions or seizures.
- Cannot recognize people or places.
- Are getting more and more confused, restless, or agitated.
- Have unusual behavior.
- Lose consciousness (*a brief loss of consciousness should be taken seriously and the person should be carefully monitored*).

### Danger Signs in Children

Take your child to the emergency department right away if they received a bump, blow, or jolt to the head or body, and:

- Have any of the danger signs for adults listed above.
- Will not stop crying and cannot be consoled.
- Will not nurse or eat.

## Related Links

- [Facts about Concussion and Brain Injury: Where to Get Help \(/concussion/get\\_help.html\)](/concussion/get_help.html)
- [Heads Up: Brain Injury in Your Practice \(/concussion/HeadsUp/physicians\\_tool\\_kit.html\)](/concussion/HeadsUp/physicians_tool_kit.html)

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Centers for Disease Control and Prevention 1600 Clifton Rd. Atlanta, GA 30333, USA



## Centers for Disease Control and Prevention

CDC 24/7: Saving Lives. Protecting People.™

Due to the lapse in government funding, only web sites supporting excepted functions will be updated unless otherwise funded. As a result, the information on this website may not be up to date, the transactions submitted via the website may not be processed, and the agency may not be able to respond to inquiries until appropriations are enacted.





Updates regarding government operating status and resumption of normal operations can be found at <http://www.usa.gov>.

## Concussion

### What are the Signs and Symptoms of Concussion?

Most people with a concussion recover quickly and fully. But for some people, symptoms can last for days, weeks, or longer. In general, recovery may be slower among older adults, young children, and teens. Those who have had a concussion in the past are also at risk of having another one and may find that it takes longer to recover if they have another concussion.

**Symptoms of concussion usually fall into four categories:**

|  Thinking/<br>Remembering |  Physical |  Emotional/<br>Mood |  Sleep |
|---|--|--|---|
| Difficulty thinking clearly   | Headache<br><br>Fuzzy or blurry vision   | Irritability   | Sleeping more than usual  |
| Feeling slowed down   | Nausea or vomiting (early on)<br><br>Dizziness   | Sadness  | Sleep less than usual   |
| Difficulty concentrating  | Sensitivity to noise or light<br><br>Balance problems                                      | More emotional   | Trouble falling asleep  |
| Difficulty remembering new information  | Feeling tired, having no energy  | Nervousness or anxiety   |   |

Some of these symptoms may appear right away, while others may not be noticed for days or months after the injury, or until the person starts resuming their everyday life and more demands are placed upon them. Sometimes, people do not recognize or admit that they are having problems. Others may not understand why they are having problems and what their problems really are, which can make them nervous and upset.

The signs and symptoms of a concussion can be difficult to sort out. Early on, problems may be missed by the person with the concussion, family members, or doctors. People may look fine even

## UHSAA Sports Concussion Management Policy

(Updated and Revised 8/17/2011)

**APPENDIX A: Statement Acknowledging Receipt of Education and Responsibility to report signs or symptoms of concussion to be included as part of the "Participant and Parental Disclosure and Consent Document".**

I, \_\_\_\_\_, of \_\_\_\_\_ High School  
*Student/Athlete Name School*

hereby acknowledge having received education about the signs, symptoms, and risks of sport related concussion. I also acknowledge my responsibility to report to my coaches, parent(s)/guardian(s) any signs or symptoms of a concussion.

\_\_\_\_\_  
*signature and printed name of student/athlete*

\_\_\_\_\_  
*Date*

I, the parent/guardian of the student athlete named above, hereby acknowledge having received education about the signs, symptoms, and risks of sport related concussion.

\_\_\_\_\_  
*signature and printed name of parent/guardian*

\_\_\_\_\_  
*Date*



## **PRE-PARTICIPATION EXAMINATION FORM**

Instructions for completing pre-participation (athletic)  
Health Examination and Consent Form

### **COMPLETING THIS FORM:**

1. PLEASE TYPE OR PRINT LEGIBLY
2. Parent/Guardian along with the student are to complete the Health History on page 3 and the Disclosure and Consent Document on page 2. Please note student and parent are to sign both forms. The Health History is to be taken to the physical examination for the physician/provider to review.
3. Physician/Provider is to complete and sign the Physical Examination form on page 4.
4. Entire completed form is to be returned to school administration.

### **SUBMITTING THIS FORM:**

1. School personnel should review form to assure it is completed properly.
2. ORIGINAL copy is to be retained in school files.

A health examination must be performed annually and the Pre-participation Physical Evaluation Form must be completed before any student may participate in athletic activities sponsored by this Association. A Pre-participation Physical Evaluation Form along with the Disclosure and Consent Document must be on file at the school before any participation in athletic activities.

The health examination may be completed and the form signed by any Medical Doctor (MD), Doctor of Osteopathy (DO), Physician's Assistant (PAC), Chiropractic Physician (DC), or Registered Nurse Practitioner (RNP) functioning within the legal scope of their practice.

THE UTAH HIGH SCHOOL ACTIVITIES ASSOCIATION DOES NOT PROVIDE PRINTED  
COPIES OF THIS FORM. PLEASE MAKE ALL NECESSARY COPIES.





## Participant & Parental Disclosure and Consent Document

PLEASE NOTE: It is the responsibility of the parent/guardian to notify the school if there are any unique individual problems that are not listed on the Pre-participation Physical Evaluation Form.

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

School \_\_\_\_\_

Is the student covered by health/accident insurance? ☐ Yes ☐ No

Name of health insurance provider \_\_\_\_\_

If no insurance provider, explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### CONSENT FORM

#### Parent or Guardian Statement of Permission, Approval, and Acknowledgement:

By signing below, I the parent or legal guardian of the above named student do:

- Hereby consent to the above named student participating in the interscholastic athletic program at the school listed above. This consent includes travel to and from athletic contests and practice sessions.
- Further consent to treatment deemed necessary by health care providers designated by school authorities for any illness or injury resulting from his/her athletic participation.
- Recognize that a risk of possible injury is inherent in all sports participation. I further realize that potential injuries may be severe in nature including such conditions as: fractures, brain injuries, paralysis or even death.
- Acknowledge and give consent that a copy of this form will remain in the student's school. I agree that if my student's health changes and would alter this evaluation, I will notify the school as soon as possible but within no longer than 10 days.
- Hereby acknowledge having received education including receiving written information regarding the signs, symptoms, and risks of sport related concussion. I also acknowledge that I have read, understand and agree to abide by the UHSAA Concussion Management Policy and/or the policy of the school listed above. <http://www.uhsaa.org/SportsMed/ConcussionManagementPlan.pdf>

Parent or Guardian Name \_\_\_\_\_

Parent or Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

#### Student Statement

By signing below I acknowledge:

- This application to compete in interscholastic athletics for the above school is entirely voluntary on my part and is made with the understanding that I have not violated any of the eligibility rules and regulations of the Utah High School Activities Association.
- My responsibility to report to my coaches and parent(s)/guardian(s) illness or injury I experience.
- Having received education including receiving written information regarding signs, symptoms, and risks of sport related concussion. I also acknowledge my responsibility to report to my coaches and parent(s)/guardian(s) any signs or symptoms of a concussion.

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

Date \_\_\_\_\_

THIS FORM MUST BE ON FILE AT THE MEMBER HIGH SCHOOL PRIOR TO PARTICIPATION.

# PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam \_\_\_\_\_  
Name \_\_\_\_\_ Date of birth \_\_\_\_\_  
Sex \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.  
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

| GENERAL QUESTIONS  | Yes | No |
|--|-----|----|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason?   |     |    |
| 2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections<br>Other: _____   |     |    |
| 3. Have you ever spent the night in the hospital?  |     |    |
| 4. Have you ever had surgery?  |     |    |
| HEART HEALTH QUESTIONS ABOUT YOU   | Yes | No |
| 5. Have you ever passed out or nearly passed out DURING or AFTER-exercise?   |     |    |
| 6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?   |     |    |
| 7. Does your heart ever race or skip beats (irregular beats) during exercise?  |     |    |
| 8. Has a doctor ever told you that you have any heart problems? If so, check all that apply:<br><input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur<br><input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection<br><input type="checkbox"/> Kawasaki disease Other: _____ |     |    |
| 9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)   |     |    |
| 10. Do you get lightheaded or feel more short of breath than expected during exercise?   |     |    |
| 11. Have you ever had an unexplained seizure?  |     |    |
| 12. Do you get more tired or short of breath more quickly than your friends during exercise?   |     |    |
| HEART HEALTH QUESTIONS ABOUT YOUR FAMILY   | Yes | No |
| 13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?   |     |    |
| 14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?  |     |    |
| 15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?  |     |    |
| 16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?  |     |    |
| BONE AND JOINT QUESTIONS   | Yes | No |
| 17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?   |     |    |
| 18. Have you ever had any broken or fractured bones or dislocated joints?  |     |    |
| 19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?   |     |    |
| 20. Have you ever had a stress fracture?   |     |    |
| 21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)   |     |    |
| 22. Do you regularly use a brace, orthotics, or other assistive device?  |     |    |
| 23. Do you have a bone, muscle, or joint injury that bothers you?  |     |    |
| 24. Do any of your joints become painful, swollen, feel warm, or look red?   |     |    |
| 25. Do you have any history of juvenile arthritis or connective tissue disease?  |     |    |

| MEDICAL QUESTIONS   | Yes | No |
|---|-----|----|
| 26. Do you cough, wheeze, or have difficulty breathing during or after exercise?                                    |     |    |
| 27. Have you ever used an inhaler or taken asthma medicine?   |     |    |
| 28. Is there anyone in your family who has asthma?  |     |    |
| 29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? |     |    |
| 30. Do you have groin pain or a painful bulge or hernia in the groin area?  |     |    |
| 31. Have you had infectious mononucleosis (mono) within the last month?   |     |    |
| 32. Do you have any rashes, pressure sores, or other skin problems?   |     |    |
| 33. Have you had a herpes or MRSA skin infection?   |     |    |
| 34. Have you ever had a head injury or concussion?  |     |    |
| 35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?      |     |    |
| 36. Do you have a history of seizure disorder?  |     |    |
| 37. Do you have headaches with exercise?  |     |    |
| 38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?              |     |    |
| 39. Have you ever been unable to move your arms or legs after being hit or falling?                                 |     |    |
| 40. Have you ever become ill while exercising in the heat?  |     |    |
| 41. Do you get frequent muscle cramps when exercising?  |     |    |
| 42. Do you or someone in your family have sickle cell trait or disease?   |     |    |
| 43. Have you had any problems with your eyes or vision?   |     |    |
| 44. Have you had any eye injuries?  |     |    |
| 45. Do you wear glasses or contact lenses?  |     |    |
| 46. Do you wear protective eyewear, such as goggles or a face shield?   |     |    |
| 47. Do you worry about your weight?   |     |    |
| 48. Are you trying to or has anyone recommended that you gain or lose weight?                                       |     |    |
| 49. Are you on a special diet or do you avoid certain types of foods?   |     |    |
| 50. Have you ever had an eating disorder?   |     |    |
| 51. Do you have any concerns that you would like to discuss with a doctor?  |     |    |
| FEMALES ONLY  |     |    |
| 52. Have you ever had a menstrual period?   |     |    |
| 53. How old were you when you had your first menstrual period?  |     |    |
| 54. How many periods have you had in the last 12 months?  |     |    |

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_



# 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, 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 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 (questions 5-14).

| EXAMINATION   |              |  |
|---|--------------|--|
| Height _____  | Weight _____ | <input type="checkbox"/> Male <input type="checkbox"/> Female                                  |
| BP _____ / _____ ( _____ / _____ )  | Pulse _____  | Vision R 20/ _____ L 20/ _____ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N |
| MEDICAL   | NORMAL       | ABNORMAL FINDINGS  |
| Appearance <ul style="list-style-type: none"> <li>Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span &gt; height, hyperlaxity, myopia, MVP, aortic insufficiency)</li> </ul> |              |  |
| Eyes/ears/nose/throat <ul style="list-style-type: none"> <li>Pupils equal</li> <li>Hearing</li> </ul>   |              |  |
| Lymph nodes   |              |  |
| Heart* <ul style="list-style-type: none"> <li>Murmurs (auscultation standing, supine, +/- Valsalva)</li> <li>Location of point of maximal impulse (PMI)</li> </ul>  |              |  |
| Pulses <ul style="list-style-type: none"> <li>Simultaneous femoral and radial pulses</li> </ul>   |              |  |
| Lungs   |              |  |
| Abdomen   |              |  |
| Genitourinary (males only) <sup>†</sup>   |              |  |
| Skin <ul style="list-style-type: none"> <li>HSV, lesions suggestive of MRSA, tinea corporis</li> </ul>  |              |  |
| Neurologic <sup>‡</sup>   |              |  |
| <b>MUSCULOSKELETAL</b>  |              |  |
| Neck  |              |  |
| Back  |              |  |
| Shoulder/arm  |              |  |
| Elbow/forearm   |              |  |
| Wrist/hand/fingers  |              |  |
| Hip/thigh   |              |  |
| Knee  |              |  |
| Leg/ankle   |              |  |
| Foot/toes   |              |  |
| Functional <ul style="list-style-type: none"> <li>Duck-walk, single leg hop</li> </ul>  |              |  |

\*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

†Consider GU exam if in private setting. Having third party present is recommended.

‡Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- ☐ Cleared for all sports without restriction
- ☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for \_\_\_\_\_
- ☐ Not cleared
- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports \_\_\_\_\_
- Reason \_\_\_\_\_

Recommendations \_\_\_\_\_

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_