(updated 8/7/24) R&L ATHLETES AND PARENTS:

THE FOLLOWING PAGES ARE FORMS WHICH MUST BE COMPLETED FOR ANY STUDENT WHO PARTICIPATES IN FUSION ATHLETICS. PLEASE MAKE AS MANY COPIES AS YOU NEED PER FAMILY (ONE FOR EACH ATHLETE WHO IS COMPETING), COMPLETE, AND RETURN AS INSTRUCTED BELOW BY THE SET DEADLINE. Once turned in, these forms will stay on file for the remainder of the sports year.

- PHYSICALS must be presented to the coach or turned into Deb **ON OR BY THE FIRST DAY OF PRACTICE** in order for an athlete to begin practice.
- CONCUSSION STATEMENT to coach or Deb **by Friday, August 23**
- FOOTBALL HELMET DISCLAIMER to coach or to Deb (only for football players :) **by Friday, August 23**
- DESIGNATION & ACCEPTANCE TO ADMINISTER MEDICATION (ONLY IF YOUR ATHLETE HAS MEDICATION WHICH MUST BE TAKEN during practice or competition) to coach or to Deb **by Friday, August 23**
- PARTICIPATION FORM/STUDENT ACTIVITIES INFORMED CONSENT & INSURANCE VERIFICATION FORM (2151-NF should be turned into YOUR SCHOOL'S SECRETARY...Deb @ Richey, Susan @ Lambert **by Friday, August 23**
- ACKNOWLEDGMENT OF THE 2024-25 ATHLETE HANDBOOK AND ASSUMPTION OF RISK STATEMENT AGREEMENT to coach or to Deb **by Friday, August 23**

Cleaner physical copies found at mhsa.org under "resources" and then "sports medicine"

LOGAN HEALTH

MHSA CONFIDENTIAL ATHLETIC PREPARTICIPATION PHYSICAL EXAMINATION

Students must have a preparticipation physical examination completed yearly prior to the first practice of any sport. This examination must be certified by a licensed medical professional acting within the scope and limitations of his/her practice. While **Logan Health is the preferred medical provider of the MHSA, parents/guardians may choose their own medical provider for their Physical Examination** This certification is valid for a period of one school year. **A physical examination conducted before May 1st is not valid for participation for the following school year. All information is to remain confidential.**

HISTORY FORM

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

Athlete Name: _____ **Gender:** _____ **Grade:** _____ **Date of Birth:** _____

Home Address: _____ **Phone Number:** _____

Parent/Guardian's Name: _____ **Family Physician:** _____

Date of examination: _____ **Current school:** _____

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 (i.e. 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 the form. Circle questions if you don't know the answer.)	**YES**	**NO**		**HEART HEALTH QUESTIONS ABOUT YOUR FAMILY**	**YES**	**NO**
1. Do you have any concerns that you would like to discuss with your provider?				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)?		
2. Has a provider ever denied or restricted your participation in sports for any reason?				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)?		
3. Do you have any ongoing medical issues or recent illness?				13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		
HEART HEALTH QUESTIONS ABOUT YOU	**YES**	**NO**		**BONE AND JOINT QUESTIONS**	**YES**	**NO**
4. Have you ever passed out or nearly passed out during or after exercise?				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?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?				15. Do you have a bone, muscle, ligament, or joint injury that currently bothers you?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?				16. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?		
7. Has a doctor ever told you that you have any heart problems?				**MEDICAL QUESTIONS**	**YES**	**NO**
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography				17. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
9. Do you get light-headed or feel shorter of breath than your friends during exercise?				18. Have you ever used an inhaler or taken asthma medicine?		
10. Have you ever had a seizure?				19. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		

MEDICAL QUESTIONS (*CONTINUED*)	YES	NO		ADDITIONAL INFORMATION
20. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?				Explain any "Yes" responses to questions in the history sections below.
21. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?				
22. 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?				
23. Have you ever become ill while exercising in the heat?				
24. Do you or does someone in your family have sickle cell trait or disease?				
25. Have you had or do you have any problems with your eyes or vision?				
26. Have you ever had an eating disorder?				
27. Have you had infectious mononucleosis (mono) within the last Month?				
FEMALES ONLY	**YES**	**NO**		
28. Have you ever had a menstrual period?				
29. How old were you when you had your first menstrual period?				
30. When was your most recent menstrual period?				
31. How many periods have you had in the past 12 months?				

Name of Athlete (typed or printed): _____

Signature of Athlete: _____

PARENT'S OR GUARDIAN'S PERMISSION AND RELEASE

I certify that the information provided by the student/parent(s) is accurate to the best of my knowledge. I hereby give my consent for the above student to engage in approved athletic activities as a representative of his/her school, except those indicated above by the licensed professional. I also give my permission for the team physician, athletic trainer, or other qualified personnel to have access to information provided here as well as to give first aid treatment to this student at an athletic event in case of injury. If emergency service involving medical action or treatment is required and the parents(s) or guardian(s) cannot be contacted, I hereby consent for the student named above to be given medical care by the doctor or hospital selected by the school.

Name of Parent/Guardian (typed or printed): _____

Signature of Parent/Guardian: _____

Date: _____ Address: _____ Insurance Company: _____

Parent's Home Phone: _____ Parent's Cell Phone: _____ Parent's Work Phone: _____

ALL INFORMATION IS TO REMAIN CONFIDENTIAL

PROVIDER'S PHYSICAL EXAMINATION FORM

Athlete Name: _____ **Date of Birth:** _____

EXAMINATION: TO BE FILLED OUT BY MEDICAL PROVIDER ONLY		
Height: _____ Weight: _____		
Pulse: _____ BP: _____/_____ Vision: R 20/_____ L 20/_____ Corrected: ☐ Y ☐ N Pupils: ☐ Equal ☐ Unequal		
MEDICAL (Please initial)	**NORMAL**	**ABNORMAL FINDINGS**
Appearance (Marfan stigmata)		
Eyes/Ears/Nose/Throat (pupils equal, hearing)		
Lymph Nodes		
Heart (murmurs)		
Pulses (simultaneous femoral and radial)		
Lungs		
Abdomen		
Skin (HSV, MRSA, tinea corporis)		
Neurological		
Genitourinary (males only)		
MUSCULOSKELETAL (Please initial)	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hands/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		
Functional (double-leg squat test, single-leg squat test, box drop or step drop test)		

Notes: _____

_____

_____

CLEARANCE

☐ Cleared without restriction

☐ Cleared with recommendations for further evaluation or treatment for: _____

_____

_____

☐ Not cleared for ☐ All sports ☐ Certain sports _____ Reason: _____

Recommendations: _____

_____

_____

Name of Physician/Medical Provider [print or type]: _____ Date: _____

Address: _____ Phone: _____

Signature of Physician/Medical Provider: _____

(Updated 4/24)

R&L Student-Athlete & Parent/Legal Custodian Concussion Statement

Because of the passage of the Dylan Steiger's Protection of Youth Athletes Act, schools are required to distribute information sheets for the purpose of informing and educating student-athletes and their parents of the nature and risk of concussion and head injury to student athletes, including the risks of continuing to play after concussion or head injury. Montana law requires that each hear, before beginning practice for an organized activity, a student-athlete and the student-athlete's parent(s)/legal guardian(s) must be given an information sheet, and both parties must sign and return a form acknowledging receipt of the information to an official designated by the school or school district prior to the student · athletes participation during the designated school year. The law further states that a student-athlete who is suspected of sustaining a concussion or head injury in a practice or game shall be removed from play at the time of injury and may not return to play until the student-athlete has received a written clearance from a licensed healthcare provider.

Student-Athlete Name:_____

This form must be complete for each student-athlete, even if there are multiple student-athletes in each household.

Parent/Legal Custodial Guardian Name:_____

□**We have read the *Student-Athlete & Parent /Legal Custodian Concussion Information Sheet.* If true, please check box.**

After reading the information sheet, I am aware of the following information:

Student-Athlete Initials		Parent/Legal Custodial Initials
	A concussion is a brain injury, which should be reported to my parents, my coaches, or a medical professional if one is available.	
	A concussion can affect the ability to perform everyday activities such as the ability to think, balance, and classroom performance.	
	A concussion cannot be "seen." Some symptoms might be present right away. Other symptoms can show up hours or days after an injury.	
	I will tell my parents, my coach, and/or a medical professional about my injuries and illnesses.	N/A
	If I think a teammate has a concussion, I should tell my coach, parents, or licensed healthcare professional about the concussion.	N/A
	I will not return to play in a game or practice if a hit to my head or body causes any concussion-related symptoms.	N/A
	I will/my child will need written permission from a licensed healthcare professional to return to play or practice after a concussion.	
	After a concussion, the brain needs time to heal. I understand that I am/my child is much more likely to have another concussion or more serious brain injury if return to plan or practice occurs before concussion symptoms go away.	
	Sometimes, repeat concussions can cause serious and long-lasting problems.	
	I have read the concussion symptoms on the Concussion fact sheet.	

Student-Athlete Signature:_____ **Date:**_____

Parent/Legal Custodian Signature:_____ Date:_____

A Fact Sheet for **PARENTS**

WHAT IS A CONCUSSION?

A concussion is a brain injury. Concussions are caused by a bump or blow to the head. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

You can't see a 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 your child reports any symptoms of concussion, or if you notice the symptoms yourself, seek medical attention right away.

WHAT ARE THE SIGNS AND SYMPTOMS OF A CONCUSSION?

Signs Observed by Parents or Guardians

If your child has experienced a bump or blow to the head during a game or practice, look for any of the following signs and symptoms of a concussion:

- 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 behavior or personality changes
- Can't recall events prior to hit or fall
- Can't recall events after hit or fall

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
- Does not "feel right"

HOW CAN YOU HELP YOUR CHILD PREVENT A CONCUSSION?

Every sport is different, but there are steps your children can take to protect themselves from concussion.

- Ensure that they follow their coach's rules for safety and the rules of the sport.
- Encourage them to practice good sportsmanship at all times.
- Make sure they wear the right protective equipment for their activity (such as helmets, padding, shin guards, and eye and mouth guards). Protective equipment should fit properly, be well maintained, and be worn consistently and correctly.
- Learn the signs and symptoms of a concussion.

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

1. Seek medical attention right away. A health care professional will be able to decide how serious the concussion is and when it is safe for your child to return to sports.

2. Keep your child out of play. Concussions take time to heal. Don't let your child return to play until a health care professional says it's OK. Children who return to play too soon—while the brain is still healing—risk a greater chance of having a second concussion. Second or later concussions can be very serious. They can cause permanent brain damage, affecting your child for a lifetime.

3. Tell your child's coach about any recent concussion. Coaches should know if your child had a recent concussion in ANY sport. Your child's coach may not know about a concussion your child received in another sport or activity unless you tell the coach.

Student Participation Form/Student Activities Informed Consent & Insurance Verification Form (2151-NF)
RICHEY/LAMBERT PUBLIC SCHOOLS
TO BE RETURNED TO PARTICIPANT'S HOME SCHOOL OFFICE ON OR BEFORE THE FIRST FRIDAY

NAME: _____ _____ _____
(Last) (First) (MI)
BIRTHDATE: _____ ETHNICITY: _____ YEAR IN SCHOOL: _____
PARENT(S)/GUARDIAN: _____ PHONE:(H)_____(W) _____ Cell_____
ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____
In case of emergency and the parent cannot be reached, the following person(s) is authorized to act on our behalf.

EMERGENCY CONTACT:_____ EMERGENCY CONTACT PHONE: _____

ACTIVITY PERMISSION: *(Parent/Guardian and Student **initial** the applicable activities.)*

_____ Basketball _____ FFA _____ Golf _____ Track _____ BPA _____ School approved field trips

_____ Band/Choir _____ Cheerleading _____ Football _____ Volleyball _____ Cross Country

PARTICIPATION WARNING:
I/We give our permission for _____ to participate in organized interscholastic athletics/activities, realizing that such activity involves the potential for injury which is inherent in all sports. I/We acknowledge that even with competent coaching/advising, the use of appropriate protective equipment, and strict enforcement/observance of rules, injuries are still a possibility. On rare occasions, these injuries can be so severe as to result in total disability, paralysis, quadriplegia, or even death. Because of the dangers of participating in the above sports/activities, I recognize the importance of following coaches/advisors instructions regarding playing techniques, training, and other team rules, etc... and I agree to obey such instruction.

PARENT/GUARDIAN STATEMENT:
I/We hereby certify and affirm that I/we are parent(s)/legal guardian(s) of _____(Student). I/We understand and have read this warning and am cognizant of its terms. I/We understand that all sports/activities can involve many risks of injury including, but not limited to, those risks indicated. I/We hereby assume all risks of playing or practicing to play/participate for the above named student.

I certify that my student is physically fit and medically able to participate or have noted an applicable physical or medical diagnosis at the bottom of this form. I further certify that my student and I have read our District Student Handbook, and if applicable, the R&L Athlete's Handbook and will honor all those instructions as well as those of the District/co-op staff. Failure to do so may result in dismissal from the activity. I have been informed of these risks, understand them, and feel that the benefits of participation outweigh the risks involved. I understand any negligence arising out of the students participation in the program shall be attributed to me as comparative negligence within the meaning of Section 27-702, CA.

WAIVER OF LIABILITY:
I/We further release and waive, and agree to indemnify, hold harmless or reimburse the school district, and the individual members, agents, employees and representatives thereof, as well as sport/activity supervisors and coaches, from and against any claim which the above named student, I/we, and/or other parent(s) or guardian(s), and sibling, or any other person, firm or corporation may have or claim to have, known or unknown, directly or indirectly, for any losses, damages or in connection with the participation by the above named student. I/We understand by signing this warning, agreement to obey instructions, and assumptions of risk, I/we are waiving all rights that the above named student, I/we or any other person may have to any compensation for any physical injury that may result from participation by the above named student.

EQUIPMENT RESPONSIBILITY: I/We agree to be responsible for the safe return or replacement of all athletic and/or activity equipment issued by the school to the above named student.

TRAINING RULES:
I understand that the Lambert/Richey athletic co-op has a Training Rules Policy that prohibits certain actions by me from the first day of practice to and including the last day of the season. I have read the policy (in the Student Handbook) and understand my expectations as a participant. Participation is a privilege, not a right!

EMERGENCY MEDICAL INFORMATION:
I authorize emergency medical professionals to examine and in the event of injury or serious illness, administer emergency care to my student. I understand every effort will be made to contact the family or contact person noted below to explain the nature of the problem prior to any involved treatment. In the event it becomes necessary for the district staff in charge to obtain emergency care for my students, I understand that neither the district employee in charge of the activity nor the school district assumes financial liability for expenses incurred because of an accident, injury, illness and/or unforeseen circumstances.

The School District(s) does not provide medical insurance benefits for students who participate in activities programs. Parents or guardians may request information from the school district regarding medical insurance for students. If parents of guardians have their own insurance coverage during the student's participation, that coverage information is provided below. Or parents may notify the School District that they do not have medical insurance.

___ I have personal medical insurance to cover the student's participation:

INSURANCE (Company Name) _____
Policy # _____

____ I don't not have personal medical insurance to cover the student's participation and understand that the School District does not provide medical insurance to cover the students. I understand I will be responsible for any medical costs associated with the student's participation:

NAME OF FAMILY PHYSICIAN: _____ PHONE: _____

Please list any medications, allergies, medical problems, and/or medical concerns of the which the coach/advisor should be aware:

_____

_____

OUT OF TOWN TRAVEL:
I/We understand that the student is a member of a school group and he/she must be encouraged to travel to and from that activity on transportation provided by the school...which may be required.

The exception to this rule may be a student traveling home with a parent/guardian in which case the parent/guardian must *personally* contact the coach/advisor of the activity and sign a parental/guardian release which indicates you assume the liability of your student(s). I/We understand that should a student violate any of the school travel rules (in the Student Handbook), the parent/guardian and the superintendent and/or AD, will be notified and the student will either be held for the parent(s)/guardian(s) arrival or be sent home at the parent(s)/guardian(s) expense by the most reasonable means of transportation; or turned over to local authorities if criminal in nature.

I/WE HAVE READ, UNDERSTAND, AND AGREE TO THE INFORMATION CONTAINED IN THIS AGREEMENT AND WILL ABIDE BY THE CONTENTS OF THIS DOCUMENT.

SIGNED:_____ DATE:_____
(Parent/Guardian)

SIGNED: _____ DATE: _____
(Parent/Guardian)

SIGNED: _____ DATE: _____
(Student Participant)

Form L

R & L Fusion
Richey Schools- PO Box 60, Richey, MT 59259--- 773-5523; fax 773-5554
Lambert Schools-PO Box 260 , Lambert , MT 59243 774-333;3fax 774-3335

FUSION FOOTBALL WARNING/HELMET DISCLAIMER

Football helmets are designed to offer some protection to the players' head-not the neck and the spine.

A football helmet is not designed to protect the neck-a helmet cannot prevent cervical dislocation or fracture resulting in spinal cord injury or quadriplegia.

A football helmet cannot prevent closed head or brain injuries including concussion that might occur as a result of participating in the game of football.

A football helmet cannot prevent or eliminate the risk of sustaining a concussion .

Players are not to return to play after suffering a head or brain injury without a doctor's written permission to do so.

Football is a dangerous sport. Injuries may occur as a result of intentional or accidental contact while participating in football. Even if you follow the rules, there is a chance that you can still be injured. NEVER use the helmet or the facemask as a point of contact . Each time you step onto the field there is a chance that you may be seriously injured. Injuries may include a broken bone or more serious injuries to the brain or cervical spine which could render you paralyzed or even result in death.

I have read the above warnings and accept the risks involved with my participation in football for Lambert and Richey Schools .

Football Helmet Number: _____

Participant Name & Signature:_____

I have read the above warnings and accept the risks involved for my student's participation in football for Lambert and Richey Schools .

Parent's Name & Signature: _____

LAMBERT/RICHEY SCHOOLS' DESIGNATION & ACCEPTANCE TO ADMIN MEDICATION:

Board P
Richey P

Notice Form 3416-NF(1): Administering Medicines to Students - Consent Form **St**

Original Adopted Date: 04/16/2024 | **Last Reviewed Date:** 04/16/2024

DESIGNATION AND ACCEPTANCE TO ADMINISTER MEDICATION

As a parent of a student _____ currently taking prescribed mediation, I _____ have design
authorized _____ to assist the student administering the medication in accordance with
Policy 3416. This designation and authorization include possessing the medication, providing it to the stu
appointed times, and confirming the student has ingested the medication.

I agree to accept responsibility for my student's receiving assistance from _____. This designation is st
voluntary. Any negligence arising out of my designation shall be attributed to me as comparative neglige
the meaning of Section 27-1-702, MCA. I agree that my student will abide by any directives issued by __
and failure to honor these directives may result in acceptance of this designation and authorization to be
and my being contacted to administer medication my student.

This designation is in effect for the period of _____.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Health Care Provider Date

As the parent-designated adult, I agree to assist the student in administering the identified medication at
appointed times. I agree to possess the medication until it is needed. I understand the medication must l
by the parent of the student. I confirm that I understand the method of possessing, ingesting, and timing
documented on this form. If a student refuses to comply with my directive as specified on this form, I w
the parent or emergency contact immediately.

_____ _____
Signature of Employee Date

Medication: _____
Method of Possession: _____
Dosage Provided to Student: _____
Time and Frequency Provided to Student: _____
Method of Ingestion: _____
Additional Instructions: _____

In case of emergency, contact, and take following steps: _____

Acknowledgment of the 2024-25 Athlete Handbook

I have received a copy of the R&L FUSION ATHLETE Handbook for the 2024025 School Year. I understand that the handbook contains information that my child and I may need during the school year. I understand that all students will be held accountable for their behavior and will be subject to the disciplinary consequences outlined in the handbook.

Print name of student: _____

Signature of student: _____

Signature of parent: _____

Date: _____

Assumption of Risk Statement Agreement

I, the parent/guardian of _____, am aware of and in understanding of the following Assumption of Risk Statement.

The coach/advisor/director, any other member of the school staff, or any member of the Board of Trustees will not be held liable or responsible in case of an accident incurred during practice, games, meets, matches, tournaments, concerts, or trips supervised by R&L Co-op and the Richey and Lambert Public Schools. Athletes and parents/guardians of athletes understand the inherent risks are the nature of participation in sports, and they assume responsibility for those risks. Our coaches do the best to promote safety and make that a priority in their programs. The coach/advisor/director, any other member of the school staff, or any member of the Board of Trustees will not be held liable or responsible in case of an accident incurred during practice, games, meets, matches, tournaments, concerts, or trips supervised by Lambert and/or Richey Public Schools.

Print name of student: _____

Signature of student: _____

Signature of parent: _____

Date: _____

Please return to the District Office by FRIDAY, August 23th, 2024