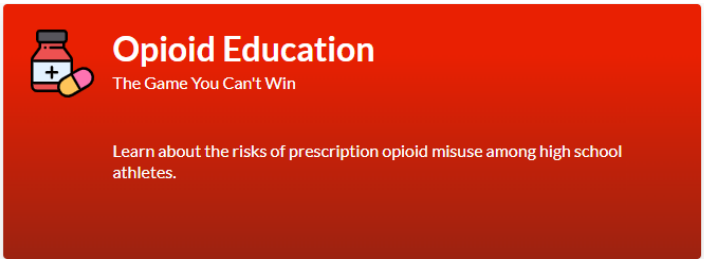
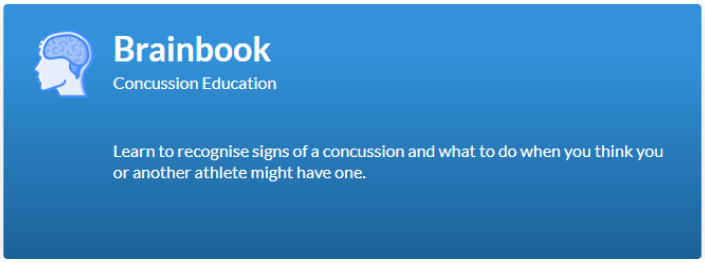
# THATCHER HIGH SCHOOL
## Arizona High School Athlete Education- AZPREPS365

In accordance with article 14.14 of the AIA Bylaws, all student athletes shall complete the Brainbook online concussion education course. All student athletes shall complete the course prior to participation in practice or competition. Note: **The Brainbook online concussion education course must be completed by a student athlete only once.**

**https://academy.azpreps365.com/**




Thatcher High School participation/athletic check list: **ALL** of these **forms** and **fees** need to be turned in before your student athlete can participate in any sport.

- ☐ AIA Annual Preparticipation physical form (6 pages)
- ☐ AIA Mild Traumatic Brain Injury (MTBI)/Concussion Annual Statement and Acknowledgment Form (1 page)
- ☐ AIA Consent to Treat Form (1 page)
- ☐ THS Insurance form (1 page)
- ☐ THS Parent Permission for School Sponsored Activity and Consent to Medical Treatment (1 page)
- ☐ THS Participation in Sports and Athletic Events Waiver, Release, and Assumption of Risk Form. (1 page)
- ☐ THS Student/Parent Handbook (1 page)
- ☐ THS Student/Athlete Parent Transport Form (1 page)
- ☐ THS FEES paid (THS bookstore or THS District Office)
- ☐ AIA Brainbook
- ☐ AIA Opioid Education

**** If your student transferred from another Arizona High School and played a sport please make sure that you contact the Athletic Director as soon as possible 928-348-7274. Please do not wait for your student's sport season.**

ARIZONA INTERSCHOLASTIC ASSOCIATION
7007 N. 18TH ST., PHOENIX, ARIZONA 85020-5552
PHONE: (602) 385-3810



# 2022-23 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

(The parent or guardian should fill out this form with assistance from the student-athlete) Exam Date: _____

Name: _____
Home Address: _____
Phone: _____
Date of Birth: _____
Age: _____
Gender: _____
Grade: _____
School: _____
Sport(s): _____
Personal Physician: _____
Hospital Preference: _____

In case of emergency contact:
Name: _____
Relationship: _____
Phone (Home): _____
Phone (Work): _____
Phone (Cell): _____

Name: _____
Relationship: _____
Phone (Home): _____
Phone (Work): _____
Phone (Cell): _____

Explain "Yes" answers on the following page.
Circle questions you don't know the answers to.

| | Y | N |
|---|---|---|
| 1) Has a doctor ever denied or restricted your participation in sports for any reason? | ☐ | ☐ |
| 2) Do you have an ongoing medical conditional (like diabetes or asthma)? | ☐ | ☐ |
| 3) Are you currently taking any prescription or nonprescription (over-the-counter) medicines or supplements? (Please specify): _____ | ☐ | ☐ |
| 4) Do you have allergies to medicines, pollens, foods or stringing insects? (Please specify): _____ | ☐ | ☐ |
| 5) Does your heart race or skip beats during exercise? | ☐ | ☐ |
| 6) Has a doctor ever told you that you have (check all that apply): | ☐ | ☐ |
| ☐ High Blood Pressure ☐ A Heart Murmur ☐ High Cholesterol ☐ A Heart Infection | | |
| 7) Have you ever spent the night in a hospital? | ☐ | ☐ |
| 8) Have you ever had surgery? | ☐ | ☐ |
| 9) Have you ever had an injury (sprain, muscle/ligament tear, tendinitis, etc.) that caused you to miss a practice or game? (If yes, check affected area in the box below in question 11) | ☐ | ☐ |
| 10) Have you had any broken/fractured bones or dislocated joints? (If yes, check affected area in the box below in question 11): | ☐ | ☐ |
| 11) Have you had a bone/joint injury that required X-rays, MRI, CT, surgery, injections, rehabilitation physical therapy, a brace, a cast or crutches? (If yes, check affected area in the box below): | ☐ | ☐ |

☐ Head ☐ Neck ☐ Shoulder ☐ Upper Arm ☐ Elbow ☐ Forearm
☐ Hand/Fingers ☐ Chest ☐ Upper Back ☐ Lower Back ☐ Hip ☐ Thigh
☐ Knee ☐ Calf/Shin ☐ Ankle ☐ Foot/Toes

| | Y | N |
|---|---|---|
| 12) Have you ever had a stress fracture? | ☐ | ☐ |
| 13) Have you ever been told that you have, or have you had an X-ray for atlantoaxial (neck) instability? | ☐ | ☐ |
| 14) Do you regularly use a brace or assistive device? | ☐ | ☐ |
| 15) Has a doctor told you that you have asthma or allergies? | ☐ | ☐ |
| 16) Do you cough, wheeze or have difficulty breathing during or after exercise? | ☐ | ☐ |
| 17) Is there anyone in your family who has asthma? | ☐ | ☐ |
| 18) Have you ever used an inhaler or taken asthma medication? | ☐ | ☐ |
| 19) Were you born without, are you missing, or do you have a non-functioning kidney, eye, testicle or any other organ? | ☐ | ☐ |
| 20) Have you had infectious mononucleosis (mono) within the last month? | ☐ | ☐ |
| 21) Do you have any rashes, pressure sores or other skin problems? | ☐ | ☐ |
| 22) Have you had a herpes skin infection? | ☐ | ☐ |
| 23) Have you ever had an injury to your face, head, skull or brain (including a concussion, confusion, memory loss or headache from a hit to your head, having your "bell rung" or getting "dinged")? | ☐ | ☐ |
| 24) Have you ever had a seizure? | ☐ | ☐ |
| 25) Have you ever had numbness, tingling or weakness in your arms or legs after being hit, falling, stingers or burners? | ☐ | ☐ |
| 26) While exercising in the heat, do you have severe muscle cramps or become ill? | ☐ | ☐ |
| 27) Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? | ☐ | ☐ |
| 28) Have you ever been tested for sickle cell trait? | ☐ | ☐ |
| 29) Have you had any problems with your eyes or vision? | ☐ | ☐ |
| 30) Do you wear glasses or contact lenses? | ☐ | ☐ |
| 31) Do you wear protective eyewear, such as goggles or a face shield? | ☐ | ☐ |
| 32) Are you happy with your weight? | ☐ | ☐ |
| 33) Are you trying to gain or lose weight? | ☐ | ☐ |
| 34) Has anyone recommended you change your weight or eating habits? | ☐ | ☐ |
| 35) Do you limit or carefully control what you eat? | ☐ | ☐ |
| 36) Do you have any concerns that you would like to discuss with a doctor? | ☐ | ☐ |

## Females Only

| | Y | N |
|---|---|---|
| 37) Have you ever had a menstrual period? | ☐ | ☐ |
| 38) How old were you when you had your first menstrual period? | _____ | |
| 39) How many periods have you had in the last year? | _____ | |

## Explain "Yes" Answers Here

ARIZONA INTERSCHOLASTIC ASSOCIATION
7007 N. 18TH ST., PHOENIX, ARIZONA 85020-5552
PHONE: (602) 385-3810



# 2022-23 ANNUAL PREPARTICIPATION PHYSICAL EXAMINATION

The physician should fill out this form with assistance from the parent or guardian.)

Student Name: _____ Date of Birth: _____

## Patient History Questions: Please Tell Me About Your Child...

| | | Y | N |
|---|---|---|---|
| 1) | Has your child fainted or passed out DURING or AFTER exercise, emotion or startle? | ☐ | ☐ |
| 2) | Has your child ever had extreme shortness of breath during exercise? | ☐ | ☐ |
| 3) | Has your child had extreme fatigue associated with exercise (different from other children)? | ☐ | ☐ |
| 4) | Has your child ever had discomfort, pain or pressure in his/her chest during exercise? | ☐ | ☐ |
| 5) | Has a doctor ever ordered a test for your child's heart? | ☐ | ☐ |
| 6) | Has your child ever been diagnosed with an unexplained seizure disorder? | ☐ | ☐ |
| 7) | Has your child ever been diagnosed with exercise-induced asthma not well controlled with medication? | ☐ | ☐ |

## Explain "Yes" Answers Here

## COVID-19...

| | | Y | N |
|---|---|---|---|
| 1) | Has your child been diagnosed with COVID-19? | ☐ | ☐ |
| | 1a) If yes, is your child still having symptoms from their COVID-19 infection? | ☐ | ☐ |
| 2) | Was your child hospitalized as a result for complications of COVID-19? | ☐ | ☐ |
| 3) | Has your child been diagnosed with Multi-Inflammatory Syndrome in Children (MIS-C)? | ☐ | ☐ |
| 4) | Did your child have any special tests ordered for their heart or lungs or were referred to a heart specialist (cardiologist) to be cleared to return to sports? | ☐ | ☐ |
| 5) | Has your child returned back to full participation in sports? | ☐ | ☐ |
| 6) | Has your child had direct or known exposure to someone diagnosed with COVID-19 in the past 3 months? | ☐ | ☐ |
| | 6a) Was your child tested for COVID-19? | ☐ | ☐ |
| 7) | Did your child receive the COVID-19 vaccine? | | |
| | 7a) What was the manufacturer of the vaccine? _____ | | |
| | 7b) Date of vaccination(s) _____ | | |

## Explain "Yes" Answers Here

## Patient Health Questionnaire Version 4 (PHQ-4)

Over the last two weeks, how often have you been bothered by any of the following problems? (circle responses)

| | Not At All | Several Days | Over Half The Days | Nearly Every Day |
|---|---|---|---|---|
| Feeling nervous, anxious, or on edge | 0 | 1 | 2 | 3 |
| Not being 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.)*

If you score a sum of 3 or greater on either questions 1 and 2, or 3 and 4, you may have anxiety or depression that is affecting you more than normal. In this case, it is recommended that you talk to a trusted health care provider such as your primary care physician, your athletic trainer at school, or a counselor at school. If there is not someone you feel comfortable talking to or you are interested in learning more to help yourself or a friend, please use the resources provided below.

For more information regarding student-athlete mental health:
Quiet Suffering - A Resource for Student-Athlete Mental Health
spark.adobe.com/page/lLtwyoLpTAp0V/

Teen Lifeline Call and Text Crisis Line
(602) 248-8336 (TEEN)
Outside Maricopa county call: 1-800-248-8336 (TEEN)
Hours are: Call 24/7/365 | Text weekdays 12-9 p.m. & weekends 3-9 p.m. | Peer counseling 3-9 p.m. daily
Crisis text line: Text HOME to 741741 to connect with a crisis counselor

National Suicide Prevention Lifeline
1-800-273-8255 or suicidepreventionlifeline.org

The Trevor Lifeline
866-488-7386 (for gender diverse youth)

## Family History Questions: Please Tell Me About Any Of The Following In Your Family...

| | | Y | N |
|---|---|---|---|
| 1) | Are there any family members who had sudden/unexpected/unexplained death before age 50? (including SIDS, car accidents drowning or near drowning) | ☐ | ☐ |
| 2) | Are there any family members who died suddenly of "heart problems" before age 50? | ☐ | ☐ |
| 3) | Are there any family members who have unexplained fainting or seizures? | ☐ | ☐ |
| 4) | Are there any relatives with certain conditions, such as: | ☐ | ☐ |

| | Y | N | | Y | N |
|---|---|---|---|---|---|
| Enlarged Heart | ☐ | ☐ | Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT) | ☐ | ☐ |
| Hypertrophic Cardiomyopathy (HCM) | ☐ | ☐ | Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC) | ☐ | ☐ |
| Dilated Cardiomyopathy (DCM) | ☐ | ☐ | Marfan Syndrome (Aortic Rupture) | ☐ | ☐ |
| Heart Rhythm Problems | ☐ | ☐ | Heart Attack, Age 50 or Younger | ☐ | ☐ |
| Long QT Syndrome (LQTS) | ☐ | ☐ | Pacemaker or Implanted Defibrillator | ☐ | ☐ |
| Short QT Syndrome | ☐ | ☐ | Deaf at Birth | ☐ | ☐ |
| Brugada Syndrome | ☐ | ☐ | | | |

## Explain "Yes" Answers Here

**I hereby state that, to the best of my knowledge, my answers to all of the above questions are complete and correct. Furthermore, I acknowledge and understand that my eligibility may be revoked if I have not given truthful and accurate information in response to the above questions.**

_____ _____ _____
Signature of Student-Athlete | Signature of Parent/Guardian | Date

_____ _____
Signature of MD/DO/ND/NMD/NP/PA-C/CCSP | Date

**ARIZONA INTERSCHOLASTIC ASSOCIATION**
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NextCare URGENT CARE

**The Preferred Urgent Care of the Arizona Interscholastic Association**

# 2022-23 ANNUAL PREPARTICIPATION PHYSICAL EXAMINATION

Name:_____ Date of Birth: _____
Age: _____ Sex: _____
Height: _____ Weight:_____
% Body Fat (optional): _____ Pulse: _____
BP: ____ / ____ (____ / ____,____ / ____)
Vision: R20/____ L20/____ Corrected: Y☐ N☐
Pupils: Equal ☐ Unequal ☐

| | Normal | Abnormal Findings | Initials * |
|---|---|---|---|
| **Medical** | | | |
| Appearance | | | |
| Eyes/Ears/Throat/Nose | | | |
| Hearing | | | |
| Lymph Nodes | | | |
| Heart | | | |
| Murmurs | | | |
| Pulses | | | |
| Lungs | | | |
| Abdomen | | | |
| Genitourinary & | | | |
| Skin | | | |
| **Musculoskeletal** | | | |
| Neck | | | |
| Back | | | |
| Shoulder/Arm | | | |
| Elbow/Forearm | | | |
| Wrist/Hands/Fingers | | | |
| Hip/Thigh | | | |
| Knee | | | |
| Leg/Ankle | | | |
| Foot/Toes | | | |

* - Multi-examiner set-up only | & - Having a third party present is recommended for the genitourinary examination

NOTES:

Cleared Without Restriction ☐
Cleared With Following Restriction: _____
Not Cleared For: All Sports Certain Sports:_____ Reason: _____
Medically eligible for all sports without restriction with recommentations for further evaluation or treatment of:

_____

Recommendations:_____

Name of Physician (Print/Type): _____ Exam Date: _____
Address: _____ Phone: _____
Signature of Physician: _____ , MD/DO/ND/NMD/NP/PA-C/CCSP

**FORM 15.7-B 02/23/2022 (rev.)** NextCare is the preferred partner of the AIA. It is not required you visit NextCare locations for your healthcare needs.

AIA ARIZONA INTERSCHOLASTIC ASSOCIATION™

OUR STUDENTS, OUR TEAMS . . . OUR FUTURE.

# Arizona Interscholastic Association, Inc.
# Mild Traumatic Brain Injury (MTBI) / Concussion
# Annual Statement and Acknowledgement Form

I, _____ (student), acknowledge that I have to be an active participant in my own health and have the direct responsibility for reporting all of my injuries and illnesses to the school staff (e.g., coaches, team physicians, athletic training staff). I further recognize that my physical condition is dependent upon providing an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries and/or disabilities experienced before, during or after athletic activities.

**By signing below, I acknowledge:**

- My institution has provided me with specific educational materials including the CDC Concussion fact sheet (http://www.cdc.gov/concussion/HeadsUp/youth.html) on what a concussion is and has given me an opportunity to ask questions.
- I have fully disclosed to the staff any prior medical conditions and will also disclose any future conditions.
- There is a possibility that participation in my sport may result in a head injury and/or concussion. In rare cases, these concussions can cause permanent brain damage, and even death.
- A concussion is a brain injury, which I am responsible for reporting to the team physician or athletic trainer.
- A concussion can affect my ability to perform everyday activities, and affect my reaction time, balance, sleep, and classroom performance.
- Some of the symptoms of concussion may be noticed right away while other symptoms can show up hours or days after the injury.
- If I suspect a teammate has a concussion, I am responsible for reporting the injury to the school staff.
- I will not return to play in a game or practice if I have received a blow to the head or body that results in concussion related symptoms.
- I will not return to play in a game or practice until my symptoms have resolved AND I have written clearance to do so by a qualified health care professional.
- Following concussion the brain needs time to heal and you are much more likely to have a repeat concussion or further damage if you return to play before your symptoms resolve.

Based on the incidence of concussion as published by the CDC the following sports have been identified as high risk for concussion; baseball, basketball, diving, football, pole vaulting, soccer, softball, spiritline and wrestling.

I represent and certify that I and my parent/guardian have read the entirety of this document and fully understand the contents, consequences and implications of signing this document and that I agree to be bound by this document.

Student Athlete:
Print Name: _____ Signature: _____ Date: _____

Parent or legal guardian must print and sign name below and indicate date signed:
Print Name: _____ Signature: _____ Date: _____

ARIZONA INTERSCHOLASTIC ASSOCIATION
7007 N. 18TH ST., PHOENIX, ARIZONA 85020-5552
PHONE: (602) 385-3810



# 2022-23 CONSENT TO TREAT FORM

Parental consent for minor athletes is generally required for sports medicine services, defined as services including, but not limited to, evaluation, diagnosis, first aid and emergency care, stabilization, treatment, rehabilitation and referral of injuries and illnesses, along with decisions on return to play after injury or illness. Occasionally, those minor athletes require sports medicine services before, during and after their participation in sport-related activities, and under circumstances in which a parent or legal guardian is not immediately available to provide consent pertaining to the specific condition affecting the athlete. In such instances it may be imperative to the health and safety of those athletes that sports medicine services necessary to prevent harm be provided immediately, and not be withheld or delayed because of problems obtaining consent of a parent/guardian.

Accordingly, as a member of the Arizona Interscholastic Association (AIA), _____ (name of school or district) requires as a pre-condition of participation in interscholastic activities, that a parent/guardian provide written consent to the rendering of necessary sports medicine services to their minor athlete by a qualified medical provider (QMP) employed or otherwise designated by the school/district/AIA, to the extent the QMP deems necessary to prevent harm to the student-athlete. It is understood that a QMP may be an athletic trainer, physician, physician assistant or nurse practitioner licensed by the state of Arizona (or the state in which the student-athlete is located at the time the injury/illness occurs), and who is acting in accordance with the scope of practice under their designated state license and any other requirement imposed by Arizona law. In emergency situations, the QMP may also be a certified paramedic or emergency medical technician, but only for the purpose of providing emergency care and transport as designated by state regulation and standing protocols, and not for the purpose of making decisions about return to play.

**PLEASE PRINT LEGIBLY OR TYPE**

"I, _____, the undersigned, am the parent/legal guardian of, _____, a minor and student-athlete at _____ (name of school or district) who intends to participate in interscholastic sports and/or activities.

I understand that the school/district/AIA employs or designates QMP's (as defined above) to provide sports medicine services (as also defined above) to the school's interscholastic athletes before, during or after sport-related activities, and that on certain occasions there are sport-related activities conducted away from the school/district facilities during which other QMP's are responsible for providing such sports medicine services. I hereby give consent to any such QMP to provide any such sports medicine services to the above-named minor. The QMP may make decisions on return to play in accordance with the defined scope of practice under the designated state license, except as otherwise limited by Arizona law. I also understand that documentation pertaining to any sports medicine services provided to the above-named minor, may be maintained by the QMP. I hereby authorize the QMP who provides such services to the above-named minor to disclose such information about the athlete's injury/illness, assessment, condition, treatment, rehabilitation and return to play status to those who, in the professional judgment of the QMP, are required to have such information in order to assure optimum treatment for and recovery from the injury/illness, and to protect the health and safety of the minor. I understand such disclosures may be made to above-named minor's coaches, athletic director, school nurse, any classroom teacher required to provide academic accommodation to assure the student-athlete's recovery and safe return to activity, and any treating QMP.

If the parent believes that the minor is in need of further treatment or rehabilitation services for the injury/illness, the minor may be treated by the physician or provider of his/her choice. I understand, however, that all decisions regarding same day return to activity following injury/illness shall be made by the QMP employed/designated by the school/district/AIA.

Date: _____ Signature: _____

**THATCHER UNIFIED SCHOOLS- SCHOOL YEAR 20____TO 20___**

NAME _____ DATE OF BIRTH _____ GRADE_____

PHONE NUMBER: FATHER _____ MOTHER _____

IF AN EMERGENCY OCCURS AND PARENTS CANNOT BE CONTACTED, PLEASE NOTIFY:

_____ _____

NAME PHONE NUMBER

**ARIZONA INTERSCHOLASITC ASSOCIATION ELIGIBILITY CARD/PARENT CONSENT**

I/WE GIVE OUR PERMISSION FOR _____ TO PARTICIPATE IN ORGANIZED INTERSCHOLASTIC ATHLETICS, REALIZING THAT SUCH ACTIVITY INVOLVES THE POTENTIAL FOR INJURY WHICH IS INHERENT IN ALL SPORTS. I/WE ACKNOWLEDGE THAT EVEN WITH THE BEST COACHING, USE OF PROTECTIVE EQUIPTMENT AND STRICT OBSERVANCE OF RULES INJURIES ARE STILL A POSSIBILITY. ON RARE OCCASIONS THESE INJURIES CAN BE SO SEVERE AS TO RESULT IN TOTAL DISABILTY, PARALYSIS, QUADRAPLEGUA OR EVEN DEATH.

I/WE ACKNOWLEDGE THAT WE HAVE READ AND UNDERSTAND THE ABOVE WARNING.

_____

STUDENT PARTICIPANT/STUDENT ATHLETE PARENT/GUARDIAN

**EXTRA-CURRICULAR ACTIVITIES INSURANCE**

I CERTIFY I/WE HAVE MEDICAL AND HOSPITAL INSURANCE TO COVER THE ABOVE-NAMED STUDENT. THE NAME OF OUR INSURANCE COMPANY IS AS FOLLOWS:

NAME OF COMPANY _____ POLICY # _____

ADDRESS OF COMPANY_____ GROUP # _____

SIGNATURE OF PARENT/GUARDIAN_____ DATE _____

I/We do not have medical and hospital insurance to cover the above-named student.
(This should be completed only if the preceding section was not completed.)

FOR OFFICIAL USE ONLY: RECEIVED BY:_____DATE PAID _____

**CONSENT FOR EMERGENCY CARE**

BE IT KNOWN that I the undersigned parent/guardian of the student named above, do hereby give and grant unto any medical doctor or hospital, my consent and authorization to render such aid, treatment or care to said students as, in the judgment of said doctor or hospital may be required, on an emergency basis, in the event said student should be injured or stricken ill while participating in an interscholastic activity, sponsored or sanctioned by ARIZONA INTERSCHOLASTIC ASSOCIATION, INC of which THATCHER HIGH SCHOOL is a member.

It is hereby understood that the consent and authorization hereby and granted and continuing, and are intended by me to extend throughout the current school year.

DATED THE_____DAY OF_____20__, at Thatcher, Arizona

_____

Parent/Guardian Witness

# Thatcher High School

## Parent Permission for School Sponsored Activity and Consent to Medical Treatment

Please complete both top and bottom of form **Parents please fill out the highlighted section**

(Name of Student)_____has the opportunity to participate in a school activity away from school premises. If you approve the following arrangement, please sign at the bottom of this section and return to the faculty sponsor.

ACTIVITY_____

DESTINATION_____

DATE_____TIME OF DEPARTURE_____DATE/TIME OF RETURN_____

TRIP SUPERVISIOR _____

MEANS OF TRANSPORTATION: (Sponsor please check)
District-owned bus_____
Commercial (Name of company)_____
Other (Specify)_____

**Parents please fill our highlighted section**

I understand the nature of the school activity in which my son/daughter will be participating and that he/she is expected to abide by all school regulations during the course of the activity.

I hereby give my permission for him/her to participate in the above-described activity.

I further agree that, in the event of an accident, illness or any other circumstance requiring medical treatment, such treatment may be procured for my son/daughter without financial obligation to the district.

Date:_____Signature of Parent/Guardian _____

IMPORTANT MEDICAL INFORMATION THE SUPERVISOR SHOULD KNOW:_____

EMERGENCY TELEPHONE NUMBERS: _____

THIS FORM SHOULD BE KEPT BY THE CHAPERONE DURING THE ACTIVITY
(Please complete the form below)
AUTHORIZATION TO TREAT A MINOR

I (We), the undersigned parent, parents or legal guardian of_____, a minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis and treatment and emergency hospital care which is deemed advisable by and is to be rendered under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medicine Practice Act and on the staff of any acute general hospital holding a current license to operate a hospital from the State of Arizona Department of Public Health. It is understood that effort shall be made to contact the undersigned prior to rending treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

Date:_____ Signature of _____
Parent/ Guardian

Allergies to Drugs or Foods _____

**PLEASE COMPLETE BOTH TOP AND BOTTOM OF FORM**

**MISSION**
To provide an appropriate and outstanding educational experience for every student served.


**DISTRICT ADMINISTRATION**
3490 W. Main Street
Phone: (928) 348-7200
Fax: (928) 348-7220


***Set to SOAR***


**JACK DALEY PRIMARY SCHOOL**
3615 W. Second Street
Phone: (928) 348-7240
Fax: (928) 348-7243


***Champions for Children***


**THATCHER ELEMENTARY SCHOOL**
1386 N. Fourth Avenue
Phone: (928) 348-7250
Fax: (928) 348-7253


***Nurturing Success***


**THATCHER MIDDLE SCHOOL**
1130 N. Fourth Avenue
Phone: (928) 348-7260
Fax: (928) 348-7263


***A great place for kids to learn!***


**THATCHER HIGH SCHOOL**

601 N. Third Avenue
Phone: (928) 348-7270
Fax: (928) 348-7273


***Building on Traditions, Creating Excellence***

**THATCHER UNIFIED SCHOOL DISTRICT #4**

# PARTICIPATION IN SPORTS & ATHLETIC EVENTS 2022-23
# WAIVER, RELEASE, AND ASSUPMTION OF RISK FORM

On behalf of myself, my household members, and my minor child,_____, I hereby give permission for my child to participate in the following sports program and/or athletic events:_____(collectively "Sports Program") at THATCHER HIGH SCHOOL. My child and I are familiar with, and knowingly and voluntarily accept, any and all risks associated with participation in the Sports Program at THATCHER HIGH SCHOOL. I acknowledge that my child's participation in this program is wholly voluntary and is not part of any regular school curriculum.

I specifically assume all risks and hazards associated with my child's participation in the Sports Program including, but not limited to, the risks associated with the novel COVID-19 virus. I understand that my child will be associating with staff and other children and may contract COVID-19, and other viruses and diseases, through my child's participation in the Sports Program. Although the children and staff may have their temperatures taken prior to participating, that precaution is not nearly adequate to prevent the spread of COVID-19 given, among other things, the relatively long incubation period, and the fact that many infected persons are asymptomatic. I understand and voluntarily assume the risk that my child may acquire COVID-19, and that COVID-19 may subsequently be transmitted from my child to me, my family, and members of my household.

While instruction and reasonable supervision will be provided, staff cannot ensure my child's safety. Accidents and injuries happen, and it is impossible to eliminate the risk that my child will suffer an injury or illness.

I certify that my child is in good health, has no fever, and has no current issues that make it unsafe for my child to participate in the Sports Program, which may not have a medical professional on staff. I will notify the school and not send my child to the Sports Program if my child develops a fever or illness or tests positive for COVID-19. I acknowledge that my child and I are responsible for ensuring that he or she takes any necessary medication, and for avoiding any allergies. In the event of a medical emergency, 911 will be called and I will be responsible for any and all costs of medical treatment.

To the fullest extent permitted by law, I hereby agree to waive, release, and discharge any and all claims, causes of action, damages, and rights of any kind against the school, the school district, its insurers, the district's governing board, and all of their respective employees, agents, representatives, and volunteers (the "Released Parties") arising from or relating in any way to any damage, injury, trauma, illness, loss, unwanted contact, harassment, disability, dismemberment, or death that may occur to my child, me, or my household members—whatever the cause—due to my child's participation in the Sports Program. This includes, without limitation, any claim arising from the negligence of the Released Parties.

I further agree not to sue the Released Parties, and to defend and indemnify the Released Parties for all claims, damages, losses, or expenses, including attorneys' fees, if a suit is filed concerning an injury, illness, or death to me, my child, or my household members resulting from participation in the Sports Program.

Parent/Guardian Name (Printed)

_____

Parent/Guardian Signature

_____ Date: _____

# THATCHER HIGH SCHOOL
# STUDENT-PARENT HANDBOOK
# 2022-2023

We the parent/guardian of_____(student) understand that the 2022-2023 THS STUDENT-PARENT HANDBOOK is on the THS Website. It is our responsibility to review Thatcher High Schools' policies and procedures. We will support the requirements, regulations, and responsibilities.

X_____

Date
Parent/Guardian signature

I,_____(student) understand that the 2022-2023 THS STUDENT-PARENT HANDBOOK is on the THS Website. It is our responsibility to review Thatcher High Schools' policies and procedures. We will support the requirements, regulations, and responsibilities.

X_____

Date
Students signature

***NOTE: It is the responsibility of students and parents to inform themselves of current Board policies and of administrative and school rules regarding conduct that is subject to disciplinary action. BOARD policies can be found at [www.thatcherud.org](http://www.thatcherud.org)***

# THATCHER UNIFIED SCHOOLS #4

# Student/Athlete Parent Transport Form:

Parent/Guardian,

**This form is required to transport your son/daughter home from an athletic contest or to an away game.** Please complete the form and turn it into the Athletic Secretary, Mrs. Turley, the THS Athletic Director and/or Coach for each sport has the right to refuse approval of parent transport.

Student Athlete Printed Name_____

Parent/Guardian Printed Name_____

Parent/Guardian Signature_____

Season (s): _____