DAVID IGE
GOVERNOR

KEITH HAYASHI
INTERIM SUPERINTENDENT

STATE OF HAWAII
DEPARTMENT OF EDUCATION
Niu Valley Middle School
An International Baccalaureate MYP World School
310 HALEMAUMAU STREET
HONOLULU, HAWAII 96821-2099 USA
Ph. (808) 377-2440, Fax (808) 377-2444
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Niu Valley Middle School Extramural Sports Program Consent and Release Form

Mission Statement

Students will learn sportsmanship, cooperation, and responsibility, while developing skills and character, with an emphasis on having fun and participating without being cut for lack of athletic ability.

Parent Permission Form

I do hereby grant permission for my child, _____, to participate in all (may include, but not limited to, cross country, volleyball, basketball, soccer and dance) of the Extramural Sports Program for Niu Valley Middle School, during the school year 2021-2022.

I also release the coaches, teachers and the administration from any responsibility or liability for personal injury that may occur while participating in the program. I understand that all insurance and medical costs related to any injury are the sole responsibility of the parent/guardian.

I further consent to allow the student to travel as a team member in local events. I also authorize the coach, school authorities, or physician as determined by school authorities to provide any emergency care and /or follow up treatment that may be necessary for the student.

_____ _____

Parent/Guardian Signature Date

Niu Valley Middle School

WORLD CLASS EDUCATION

International Baccalaureate

Emergency Information

Student's Name _____ Grade _____ Advisory _____

Extramural Sport(s) _____

Birthdate _____ Home Phone Number _____

Father's/Guardian's Name _____ Cell Number _____*

Mother's/Guardian's Name _____ Cell Number _____*

Email address _____@_____**

Health and/or Insurance Carrier: _____ Policy #: _____

List any medical conditions: _____

_____

When the student becomes ill or incurs an injury during the extramural activity and I am unable to be contacted, the school has my permission to contact and release the student to the custody of any of the following persons(you may add additional names/numbers on the back of this form):

Name	Relationship	Phone Number(s)
_____	_____	_____
_____	_____	_____

Family Physician: _____ Phone Number: _____

If my child needs to be taken to an emergency facility, he/she will be taken to the nearest one. I give my consent for school authorities to take appropriate action for the safety and welfare of my child.

Preferred hospital/clinic _____

Please notify the school's Extramural Coordinator of any change in phone numbers.

_____ _____

Parent/Guardian Signature Date

*At least one emergency contact is required

**Please provide at least one email address where we can contact you in case there are any last minute schedule changes. Additional email addresses may be listed on the back of this form.

Niu Valley Middle School

Hawaii State Department of Education
PHYSICAL EXAMINATION FOR ATHLETES

Student's Name _____ M/F_____ Date of Birth_____/_____/_____ Grade _____
(Print) Last First MI Month Day Year

Address_____ Home Phone_____ Student Resides With _____
Street No. City State Zip Code

Fall Sport _____ Winter Sport _____ Spring Sport _____

Father's/Guardian's Name _____ Bus. Phone _____ Cell or Pager_____

Mother's/Guardian's Name _____ Bus. Phone _____ Cell or Pager_____

Emergency Contact _____ Bus. Phone _____ Cell or Pager_____
Name & Relationship

Emergency Contact _____ Bus. Phone _____ Cell or Pager_____
Name & Relationship

Emergency Contact _____ Bus. Phone _____ Cell or Pager_____
Name & Relationship

Health and/or Insurance Carrier _____ Policy # _____

The student and parent/guardian consent and authorize school officials through an Athletic Health Care Trainer (AHCT), qualified coach/staff, or physician as determined by the school, to provide any first aid and/or emergency care as well as follow-up first aid or medical treatment that may be reasonably necessary for the student as determined by a school official in the course of athletic practice, competition or travel.

The student and parent/guardian further consent and authorize the school's AHCT to provide appropriate therapeutic modalities in order to return student to athletic competition, such care to be conducted under the direction of a physician.

The student and parent/guardian further consent and authorize the school's AHCT to administer baseline and/or post injury concussion management assessment in order to manage a concussion or suspected head trauma, such care to be conducted under the direction of a physician.

The student and parent/guardian hereby consent to the release of medical information by physician to school to obtain information regarding the medical history, records of injury or surgery, serious illness, and rehabilitation results of the student from his/her physician(s). We understand that the purpose of this request for medical information is to assist the school in the management or rehabilitation of an injury/illness. This information is confidential and except as provided in this release will not be otherwise released by the parties in charge of the information. This release remains valid until revoked by the adult student or parent/guardian in writing.

Signature of Student_____ Signature of Parent/Guardian _____Date _____
(parent/guardian fill out back side of this form)

To be completed by Physician only

Height _____ feet & inches Weight _____lbs Blood Pressure_____/_____ Pulse_____ bpm
Vision: R 20/_____ L 20/ _____ Corrected: Yes No Pupils: Equal ____ Unequal ____
Asthma _____ (Medication Used) Diabetes _____ (Medication Used) Allergies _____ (Medication Used)

MEDICAL	NORMAL	COMMENTS	INITIALS
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart/Murmurs			
Pulses			
Lungs			
Abdomen			
Skin			
Genitalia			
MUSCULOSKELETAL			
Neck			
Back/Spine			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Calf/ankle			
Foot/toes			
Other			

(Over)

Parent/Guardian and Student to fill out before Physical Examination

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

		Yes	No
1.	Has a doctor ever denied or restricted your participation in sports for any reason?	❑	❑
2.	Do you have an ongoing medical condition (like diabetes or asthma)?	❑	❑
3.	Are you currently taking any prescription or nonprescription (over the counter) medicines or pills?	❑	❑
4.	Do you have allergies to medicines, pollens, foods or stinging insects?	❑	❑
5.	Have you ever passed out or nearly passed out DURING exercise?	❑	❑
6.	Have you ever passed out or nearly passed out AFTER exercise?	❑	❑
7.	Have you ever had discomfort, pain or pressure in your chest during exercise?	❑	❑
8.	Does your heart race or skip beats during exercise?	❑	❑
9.	Has a doctor ever told you that you have: (circle all that apply) High blood pressure A heart murmur High Cholesterol A heart infection	❑	❑
10.	Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)	❑	❑
11.	Has anyone in your family died for no apparent reason?	❑	❑
12.	Does anyone in your family have a heart problem?	❑	❑
13.	Has any family member or relative died of heart problems or of sudden death before age 50?	❑	❑
14.	Has a family member died while exercising?	❑	❑
15.	Does anyone in your family have Marfan Syndrome?	❑	❑
16.	Have you ever spent the night in a hospital?	❑	❑
17.	Have you ever had surgery?	❑	❑
18.	Have you ever had an injury, like sprain, muscle or ligament tear, or tendonitis, that caused you to miss a practice or game? If yes, list affected area: _____	❑	❑
19.	Have you had any broken or fractured bones or dislocated joints? If yes, list affected area: _____	❑	❑
20.	Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, list affected area: _____	❑	❑
21.	Have you ever had a stress fracture?	❑	❑
22.	Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	❑	❑
23.	Do you regularly use a brace or assistive device?	❑	❑
24.	Has a doctor ever told you that you have asthma or wheezing?	❑	❑
	EXPLAIN "YES" answers here: **(Add additional pages if necessary)**		

		Yes	No
25.	Do you cough, wheeze or have difficulty breathing during or after exercise?	❑	❑
26.	Have you ever used an inhaler or taken asthma medicine?	❑	❑
27.	Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	❑	❑
28.	Have you had infectious mononucleosis (mono) within the last month?	❑	❑
29.	Do you have any rashes, pressure sores, or other skin problems?	❑	❑
30.	Have you had a herpes skin infection?	❑	❑
31.	Have you ever had a head injury or concussion?	❑	❑
32.	Have you been hit in the head and been confused or lost your memory?	❑	❑
33.	Have you ever had a seizure?	❑	❑
34.	Do you have headaches with exercise?	❑	❑
35.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	❑	❑
36.	Have you ever been unable to move your arms or legs after being hit or falling?	❑	❑
37.	When exercising in the heat, do you have severe muscle cramps, or become ill?	❑	❑
38.	Do you have any hearing problems?	❑	❑
39.	Do you have a hearing device?	❑	❑
40.	Do you have a family member with hearing problems?	❑	❑
41.	Has a doctor told you that you, or does someone in your family have sickle cell trait or sickle cell disease?	❑	❑
42.	Have you had any problems with your eyes or vision?	❑	❑
43.	Do you wear glasses or contact lenses?	❑	❑
44.	Do you wear protective eyewear, such as goggles or a face shield?	❑	❑
45.	Are you happy with your weight?	❑	❑
46.	Would you like to lose weight?	❑	❑
47.	Would you like to gain weight?	❑	❑
48.	Has anyone recommended you change your weight or eating habits?	❑	❑
49.	Do you limit or carefully control what you eat?	❑	❑
50.	Do you have any concerns that you would like to discuss with a doctor?	❑	❑
51.	Do you feel depressed?	❑	❑
52.	Do you have a history of multiple or long nosebleeds?	❑	❑
53.	**MALES ONLY:** Do you ever have or had swelling of your testicles or groin?	❑	❑
	FEMALES ONLY		
54.	Have you ever had a menstrual period?	❑	❑
55.	How many periods have you had in the last 12 months?	____	

I hereby verify to the best of my knowledge that the answers which have been provided to the above questions are correct.

Signature of Student_____ Signature of Parent/Guardian _____Date _____

Clearance: (Place a check in appropriate box below)

- ❑ Cleared for all sports
- ❑ Cleared after completing evaluation/rehabilitation for _____
- ❑ Not cleared for:
  - ❑ Collision (Football)
  - ❑ Contact (Baseball, Basketball, Cheerleading, Judo, Softball, Soccer, Volleyball, Wrestling)
  - ❑ Non contact ❑ Strenuous ❑ Moderately Strenuous ❑ Non-strenuous

Reason not cleared: _____

Physician's Recommendation _____

Name of Physician _____ **Date of Physical Exam** _____

Address _____ **Telephone** _____

Signature of Physician _____ **Fax Number** _____

Checklist for extramural participation in sports.

- ☐ Niu Valley Middle School Extramural Sports Program Consent and Release Form
- ☐ Hawaii State Department of Education Physical Examination for Athletes form
- ☐ Currently this year following OIA and REACH protocols regarding COVID-19, all students who wish to participate in extramural physical sports need to show proof of full vaccination or a negative test within 48 hours of the practice. Please provide a picture of their Vaccine Card to the school either by bringing it to the office or submitting it to the google form below. Negative tests must be presented to the coach prior to engaging in the practice. Should a child not be allowed to participate because they did not bring the negative test parents must pick up the student.
- ☐ In addition, students and parents are required to watch these safety videos about concussions found on https://hcamp.info/ad videos are linked on the form below as well.
- ☐ Please submit a response to this google form https://bit.ly/NVMSsports certifying that you and your student have watched the videos.