



Kalani High School
Athletic Department
4680 Kalanianaʻole Highway
Honolulu, Hawaii 96821
(808) 377-7744 Ext. 320

July 29, 2009

Dear Parent/Guardian:

Welcome to Kalani High School's Athletic Program.

These forms have been presented to you because your child has indicated a desire to participate in interscholastic athletics and you have expressed your willingness to permit him/her to compete. Your interest in our school's athletic program is very important and we hope that this will continue throughout your child's high school career. We believe that participation in sports provides a wealth of opportunities and experiences that will assist your child's personal growth.

There are several steps required before your child may participate in athletics. These attached forms are the first step and must be **completed** in its entirety, signed and turned into the Athletic Health Care Trainer **prior** to your child's participation in any sports activity (this includes preseason conditioning and tryouts):

1. Hawaii State Department of Education Physical Examination for Athletes

Please bring this form to your child's physical appointment and have the doctor complete and sign the front. You and your child need to complete and sign the back of the form. The physical is good for one year from the date of the completed physical and will be kept on file with the school's Athletic Health Care Trainer. **Please plan early.** Missing tryouts due to the lack of a physical may prevent your child from participating in that sport.

2. Student Participation and Parent/Guardian Consent, Release and Assumption of Risk Form

Please carefully read and complete both sides of this form. You will need to complete this form for **EACH** sport your child participates in. You and your child need to sign this form. The form will be kept on file with the school's Athletic Health Care Trainer.

The completion and submission of all forms will be strictly enforced. **Your child will not be allowed to participate in any team activities until these forms have been submitted to the proper personnel.** If you should have any questions regarding the forms, you may call the Athletics Director at 377-7744 ext. 320 or contact the Athletic Trainer at 377-7744 ext. 325. Additional forms are available at the main office, athletics office located in the gym or the athletic trainers office. You may also download these forms at www.kalanisports.com.

We look forward to your child's participation and your continued support of Kalani Athletics.

Sincerely,

Gregory S. Van Cantfort, CAA
Director of Athletics

**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

Health and/or Insurance Carrier _____ Policy # _____

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			

Clearance:

- A. Cleared for all sports _____
 B. Cleared after completing evaluation/rehabilitation for _____
 C. Not cleared for: Collision Contact Non contact Strenuous Moderately Strenuous Non-strenuous

Due to _____

Physician's Recommendation _____

Name of Physician _____ Date of Physical Exam _____

Address _____ Telephone _____

Signature of Physician _____ Fax Number _____

(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		Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	24. Do you cough, wheeze or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have an ongoing medical condition (like diabetes or asthma)?	<input type="checkbox"/>	<input type="checkbox"/>	25. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or nonprescription (over the counter) medicines or pills?	<input type="checkbox"/>	<input type="checkbox"/>	26. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have allergies to medicines, pollens, foods or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	27. Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever passed out or nearly passed out DURING exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever passed out or nearly passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	29. Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had discomfort, pain or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	30. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
8. Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	31. Have you been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	32. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)	<input type="checkbox"/>	<input type="checkbox"/>	33. Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
11. Has anyone in your family died for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	34. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
12. Does anyone in your family have a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	35. Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
13. Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	36. When exercising in the heat, do you have severe muscle cramps, or become ill?	<input type="checkbox"/>	<input type="checkbox"/>
14. Does anyone in your family have Marfan Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	37. Has a doctor told you that you, or does someone in your family have sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	38. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	39. Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
17. 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: _____	<input type="checkbox"/>	<input type="checkbox"/>	40. Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you had any broken or fractured bones or dislocated joints? If yes, list affected area: _____	<input type="checkbox"/>	<input type="checkbox"/>	41. Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you have 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 affect area: _____	<input type="checkbox"/>	<input type="checkbox"/>	42. Would you like to lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	43. Would you like to gain weight?	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>	44. Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
22. Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>	45. Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
23. Has a doctor ever told you that you have asthma or wheezing?	<input type="checkbox"/>	<input type="checkbox"/>	46. Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
EXPLAIN "YES" answers here: (Add additional pages if necessary)			FEMALES ONLY	<input type="checkbox"/>	<input type="checkbox"/>
			47. Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
			48. 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 _____

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 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 _____

**Student Participation and Parent/Guardian
Consent, Release, and Assumption of Risk Form**

This consent, release, and assumption of risk agreement is made and entered into by and between _____, Minor Student
born _____, and _____ as parent/guardian of _____, Minor Student
Birthdate Parent/Guardian
and the Department of Education, an agency of the State of Hawaii, this _____ day of _____, 20_____.

OR

This consent, release, and assumption of risk agreement is made and entered into by and between _____, Adult Student
(i.e. Adult student is 18 years old or older at the time of this agreement), born _____, and the Department of Education,
Birthdate
an agency of the State of Hawaii, this _____ day of _____, 20_____.

WITNESSETH

Whereas _____ is a minor or an adult student (hereafter referred to as "student") attending
Student

Whereas, student is a member of the school's _____ interscholastic athletic team;
School Sport(s)

Whereas we, the student & parent/guardian, understand that competition in interscholastic athletics activities is entirely voluntary on our part. We fully understand that we must comply with the rules and regulations of the Department, League, and the Hawaii High School Athletic Association (HHSAA).

Whereas, student has been evaluated by the athletic staff of the school as well as by student's physician or therapist and has been informed of the risks associated with his/her participation in interscholastic athletic competition;

Whereas, student and parent/guardian have been apprised that no protective equipment can prevent head, neck, brain, or other bodily injury that may result from athletic competition;

Whereas, student and parent/guardian acknowledge that equipment such as football helmets must not be used to butt, spear or ram opposing players and to do so is a violation of the rules of the game and can result in serious injury to self and others; and

Whereas, student and parent/guardian, after having been informed of the risks to student, affirm that student has had full disclosure of the risks involved explained to student by the Department of Education, understand the risks, and agree to assume those risks as their own and make this decision as their own free will and not by coercion or influence from anyone.

NOW, THEREFORE, based upon the above understanding, student, for himself/herself, his/her heirs, executors, administrators and assigns, and _____, as parent/guardian of student, hereby acknowledge that they have been

Parent/Guardian of Minor Student
appraised of the risks inherent in student's participation in interscholastic athletic competition, which could result in serious bodily injury and even death, and hereby consent to the participation of student in such athletic activity and competition, agree to assume these risks as their own and hereby release the Department of Education, State of Hawaii, its officials and agents of any and all claims and liabilities whatsoever from or by reason of any athletic injury to student, while participating as a member of the _____ interscholastic
Sport
athletic team in sports activities that are sanctioned by the HHSAA, including travel.

Whereas student and parent/guardian understand that the Department of Education strongly recommends that the student have medical/health insurance coverage prior to participating in interscholastic sports activities and further understand that all insurance and medical costs related to any injury are the sole responsibility of the parent/guardian. The Department of Education will not assume and is not responsible for any of these costs.

The student and parent/guardian further consent to allow the student to travel as a team member in local, inter-island and out-of-state athletic events. The student and parent/guardian further authorize the school officials through a certified athletic health care trainer (AHCT), qualified coach/staff, or a physician as may be determined by school officials, to provide any emergency care and/or follow-up medical treatment that may be deemed by school officials to be necessary for the student in the course of such 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 hereby consent to the release of medical information by physician to the school for purposes of allowing the 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 management or rehabilitation of an injury/illness. This information is normally confidential and except as provided in this release will not be otherwise released by the parties in charge of the information. This release shall remain valid until revoked by the adult student or parent/guardian in writing.

The student and parent/guardian expressly agree that this assumption of risk and release agreement is intended to be as broad and inclusive in favor of the State of Hawaii as permitted by the laws of the State of Hawaii and that if any provision herein is held to be invalid, it is agreed that the remaining provisions shall, notwithstanding, continue in full force and effect.

The parties understand and agree that this agreement is made with full knowledge of the facts and legal implications of entering into such an agreement and they further agree that this agreement contains the entire agreement between the parties, hereto, and that the terms of this agreement are contractual and not mere recitals.

The laws of the State of Hawaii shall control this agreement.

IN WITNESS WHEREOF, the parties hereby execute this agreement, effective the date first indicated in this agreement.

Signature of Student

Signature of Parent/Guardian

Signature of Adult Student

EMERGENCY INFORMATION:

Student's Name _____ Home Telephone _____

Father's/Guardian's Name _____ Bus. Phone _____ Cell or Pager # _____ Employer _____

Mother's/Guardian's Name _____ Bus. Phone _____ Cell or Pager # _____ Employer _____

Medical Condition (allergies, prescription medicine, etc.) school should know about my child _____

Health and/or Insurance Carrier _____ Policy # _____

When the listed student becomes ill or incurs an injury during a school-sponsored activity and I am unable to be contacted, the school authorities have my permission to contact and release the student to the custody of any of the following persons:

Name	Relationship	Home Telephone	Business Telephone
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family Physician _____ Phone _____

Preferred hospital/clinic _____

To ensure prompt attention to your child, PLEASE NOTIFY SCHOOL ATHLETIC DEPT. OF ANY CHANGE IN PHONE NUMBERS OR ADDRESS.

Signature of Parent/Guardian or Adult Student _____ Date _____

ALL INFORMATION ON THIS CARD MUST BE COMPLETED FOR PARTICIPATION ELIGIBILITY.