TEMPE UNION HIGH SCHOOL DISTRICT-ATHLETICS/ACTIVITIES REGISTRATION CLEARANCE PROCEDURE FOR ALL SPORTS-BAND-CHEER

Register My Athlete allows parents to register their athletes for sports online. Here are some basic steps to follow when registering your athlete for the first time:

1) Create a parent account: Visit Register My Athlete and begin creating your account by filling in the required information. The system will automatically log you in and you will be required to accept the terms of use.

2) Add a new athlete: Under the "Parents" section, click "Start/Complete Athlete Registration". This will bring you to a registration checklist that will walk you through each step of the registration process. First you will choose Mountain Pointe as your school, then when prompted, add your athlete's information and then the sport(s) you want to register him or her for. Please double check the year you are registering for. Registrations are currently open for the 2022-2023 athletic season. Continue through the checklist until you are

3) The Athlete's Profile: After you have created your athlete, you will be prompted to complete their profile page. This page is a summary of their info and involvement.

4) Uploading Forms: Parents have the ability to download, print, and upload required physical documents to the RMA system. Uploaded documents will need to be verified by school administration prior to being accepted as complete. If a document upload is rejected for any reason, the parent will receive an email with the rejection reason. After the error has been corrected, parents will be able to re-upload the entire document for verification. If you do not have a scanner use your smart phone to take pictures of the forms and then upload to RMA. After registration is complete, you can login at any time to view the status of your athlete.

5) Impact Testing: This is a computerized test that measures memory, attention span, visual and verbal problem solving. Following a concussion, Impact Testing is a tool used by healthcare providers to help determine when an athlete is ready to participate again in their sport. This documentation is one that you can not upload. This testing will be conducted with the Athletic Trainer for the following sports/activities: Baseball, Basketball, Cheer, Dive, Football, Pole Vault, Sand Volleyball, Soccer, Softball, Volleyball, and Wrestling. Please check with your coach or the athletic office at your school for the testing date and times. Your Athlete will have a Completed status upon passing their Impact Test.

6) Brainbook & Opioid Courses: This course only needs to be completed once in an Athlete's high school athletic career. If you student is transferring from another school and has taken these courses, you may upload the certificate you received at the end of completing the course or you may contact Mountain Pointe's Athletic Department and they can contact the school you are transferring from to obtain the certificate.

7) Complete registration: Your registration is complete once all items on the checklist have been completed and verified.

**** Additional Athletes:** Under the same account, repeat steps 3-9 to register additional Athletes.
****Future Seasons:** Once an athlete has created an account with RMA follow steps 5-8 to register them for another sport in the current year.

Please bookmark the login site for future reference: Register My Athlete

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

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.

ARIZONA INTERSCHOLASTIC ASSOCIATION
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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: _____

CONSENT FOR EMERGENCY CARE

▶ _____/_____/_____/_____

Student Name **Student ID #** **Date of Birth** **Age**

▶ _____/_____/_____/_____

Parent(s)/Guardian(s) Name **Home #** **Cell #** **Work #**

▶ _____/_____/_____/_____

Address **City** **Zip** **Email**

▶ _____/_____/_____/_____

Emergency Contact-Person who can answer on your behalf for your child in an emergency **Home#** **Cell #** **Work#**

If emergency service involving medical action or treatment is required and the parent(s) or guardian(s) cannot be contacted, I hereby consent for the student named to be given medical care by the doctor or hospital selected by the school.

▶ _____

Name of Family Physician Phone Number Date of **current** physical

STATEMENT OF INSURANCE COVERAGE (All students **MUST** have some type of insurance.) Please **choose** either Option1 or Option2.

OPTION 1 I affirm that I am the parent or Legal Guardian of the student signing this form. I request that this student be exempt from the school accident insurance requirements for students participating in athletics and certain other school activities. I represent that this student is currently covered and will be covered during the present school year by an accident insurance policy which provides at least in the equivalent sums and coverage as the policy offered by the school. This includes coverage in the event of injury in a school supervised game or activity.

Company Name_____ Phone #_____ Policy #_____

OPTION 2 I/We desire insurance that will fulfill the school accident insurance requirement.

I have purchased school accident insurance (type) _____/$_____ Effective date: _____ School Official Signature: _____

HEALTH HISTORY ***(To be filled out by parent)*** **HAS YOUR CHILD EVER HAD OR NOW HAS:** ***Please circle YES (Y) and/or NO (N)***

Y	N	Allergy	Y	N	Kidney Trouble	Y	N	Diabetes	Y	N	Valley Fever	Y	N	Hepatitis	Y	N	Sprains
Y	N	Arthritis	Y	N	Migraine Headaches	Y	N	Fainting	Y	N	Heart Trouble	Y	N	Scoliosis	Y	N	Dislocations
Y	N	Back Pain	Y	N	Knocked Out	Y	N	Heart Murmur	Y	N	Spine Injury	Y	N	Sinus Trouble	Y	N	Contact Lenses
Y	N	Loss Consciousness	Y	N	Concussion	Y	N	Hernia	Y	N	Ankle Injury	Y	N	Operations	Y	N	Tuberculosis
Y	N	Eczema (Skin Rash)	Y	N	Sore Throats	Y	N	Menstrual Cramps	Y	N	Neck Injury	Y	N	Fractures	Y	N	Rheumatic Fever
Y	N	Epilepsy (Seizures)	Y	N	Anemia	Y	N	Mononucleosis	Y	N	Elbow Injury	Y	N	Hives	Y	N	Asthma
Y	N	Chest X-Ray	Y	N	Tetanus Booster	Y	N	Other									

- **If YES, give year and details:** _____
- **Medication (s) now taking:** _____ • **Medicine(s) student is allergic to:** _____
- **Does student have to stop while running ½ mile? YES NO**
- **SPORT: FALL:** _____ **WINTER:** _____ **SPRING:** _____

THIS FORM MUST BE SIGNED BY STUDENT AND PARENT OR LEGAL GUARDIAN

BE IT KNOWN, that, I, the undersigned parent/guardian of the above named student, do hereby give and grant unto any medical doctor, hospital, paramedic or certified school athletic trainer, my consent and authorization to render such aid, treatment or care to said student as, in judgment of said doctor, hospital, paramedic, or certified school athletic trainer, may be required, on an emergency basis, in the event the above-named student should be injured or stricken ill while participating in an interscholastic activity sponsored or sanctioned by Arizona Interscholastic Association, Inc. of which the above named high school is a member.

IT IS HEREBY understood the consent and authorization given are continuing, and are intended throughout the current school year.

IT IS FURTHER understood that insurance or parent of student will pay any expenses incurred. Payment of expense is not a school responsibility. "I/we recognize that the foregoing is a public document and falsification of information on that document to obtain admission to the Tempe Union High School District may constitute violation of the criminals in laws of the State of Arizona. I/we hereby certify that all the information contained in the Tempe Union High School District Athletic Participation Form is true and correct and recognize that in the event that any information in regard to residence has been falsified, I/we will be liable for nonresident tuition from the date of enrollment in the Tempe Union High School District (TUHSD)."

IT IS FURTHER understood that any falsification on this document may result in student losing a year's participation and eligibility in interscholastic athletics in the TUHSD.

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

_____ _____ _____

Student (PRINT) **Student (SIGNATURE)** **Date**

_____ _____ _____

Parent/Guardian (PRINT) **Parent/Guardian (SIGNATURE)** **Date**

BRAINBOOK AND OPIOID EDUCATION COURSES

All Student-Athletes must complete the Brainbook Concussion Course and the Opioid Education Course quizzes. Students must pass with an 80% or higher or they will have to retake the quiz. Once you have completed the courses, students should print off their certificate indicating they have passed both courses and upload the document to Register My Athlete. Athletes are only required to complete the Brainbook and Opioid Education training once during their 4-year high school career.

If you are a returning athlete and have already completed Brainbook, log onto your same account you had when you took the Brainbook course originally. Complete the Opioid Education Course. As long as you use your existing account, your certificate will show that you have successfully completed all courses including Brainbook. Upload your new certificate to Register My Athlete.

To complete the Education Courses:

1. Go to https://academy.azpreps365.com
2. If you are a NEW STUDENT-ATHLETE to Tempe Union click on Get Started.
    a. Fill out the information to register for an account.
    b. Make sure you take the course as your name. Do not take the course as someone else or as a guest. The scores will not count under your account if you do.
    c. Select your school, Grade level and for the 2020-2021 school year.
    d. Check all the sports you could be participating in
    e. Proceed to courses
    f. Once completed both courses, print off your certificate and upload to Register My Athlete
3. If you are a RETURNING STUDENT-ATHLETE that has already completed the Brainbook Concussion Course, click on Log In and sign into your account.
    a. Complete the Opioid Education Course quiz.
    b. Once completed, print off the certificate. If you have logged into your same account, the certificate will show that you have completed both courses. Upload the document to Register My Athlete.

Tempe Union
HIGH SCHOOL DISTRICT

Participation in Extracurricular Activities 2022-2023
COVID-19 Waiver, Release, and Assumption of Risk Form

On behalf of myself, my household members, and my minor child, _____, I hereby give permission for my child to participate in all of the following extracurricular activities: _____. My child and I are familiar with, and knowingly and voluntarily accept, any and all risks associated with participation in extracurricular activities at _____ (Campus). I acknowledge that my child's participation 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 extracurricular activities including, but not limited to, the risks associated with the novel COVID-19 virus. I acknowledge that while participating in extracurricular activities, my child will associate with staff and may physically contact other children and/or shared equipment, and may contract COVID-19 (and other viruses and diseases), notwithstanding any precautions taken by the school. I further acknowledge that the school cannot absolutely control the conduct of all students, guarantee that students or their parents will follow safety protocols and procedures, or prevent infected students from potentially spreading COVID-19 to my child, directly or indirectly. I understand and voluntarily assume the risk that my child may acquire COVID-19, and that the virus may subsequently be transmitted from my child to me, my family, and members of my household.

I certify that my child is in good health and has no fever. I understand that symptoms of COVID-19 include, but are not limited to, fever or chills, coughs, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting, and diarrhea. My child currently has none of these symptoms, and I will notify the school and prevent my child from participating in extracurricular activities if my child develops any of these symptoms, or if anyone in my household tests positive for COVID-19. I further certify that if my child experiences any of these symptoms, I will ensure that my child is symptom- free, without any medication, for ten (10) days before returning to extracurricular activities. I will notify the school if my child tests positive for COVID-19, and my child and I will follow all COVID-19 protocols and procedures adopted by the District or school.

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 District, the District's 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, or death that may occur to my child, me, or my household members as a result of the COVID-19 pandemic.

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 as a result of the COVID-19 pandemic.

Parent/Guardian Name (Printed) _____

Parent/Guardian Signature _____ Date _____