

Welcome to the   
**Proud Home of the Cougars**  
**Learning Today, Leading Tomorrow**

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**Combs Middle School  
Competitive Sports Program 2016-2017**

Welcome to the Combs Middle School Competitive Sports Program! CMS is a part of the Desert Mountain Middle School League and Canyon Athletic Association. Competitive sports are about building future high school athletes while, having fun, developing new skills, working together and promoting good sportsmanship.

**Sports Offered**

1<sup>st</sup> Quarter-Baseball, Softball and Competitive Flag Football

2<sup>nd</sup> Quarter-Boys' Soccer and Girls' Volleyball

3<sup>rd</sup> Quarter-Girls' Basketball and Cheerleading

4<sup>th</sup> Quarter-Boys' Basketball, Girls' Soccer and Cheerleading

**Requirements**

To participate in athletics, a student must have all of the following completed:

- ✓ **Athletic Consent Form** signed and dated by the student athlete and parent/guardian.
- ✓ **2016-2017 Annual Preparticipation Physical Evaluation Form 15.7-A**-Filled out and signed by the student and parent/guardian.
- ✓ **2016-2017 Annual Preparticipation Physical Evaluation Form 15.8-B**-Must be filled out completely by a *physician*.
- ✓ **Copy of medical insurance card**-All athletes is required to show proof of medical insurance. Student health insurance can be purchased through [www.studentinsurance-kk.com](http://www.studentinsurance-kk.com) Packets are also available in the front office.
- ✓ **Sports participation fee of \$75.00** per sport with an athlete cap of \$225.00 for the school year.

\*Sports physicals are good for one full calendar year. For example, if a student has a physician signed physical form from February of 2016 on file then the student may participate in sports until February 2017. A current copy of the medical insurance card will still be required.

**Go Cougars!**



# Combs Middle School

*"Home of the Cougars"*

37611 N. Pecan Creek Drive

San Tan Valley, AZ 85140

(480) 882-3510

[www.jocombs.org](http://www.jocombs.org)

## Athletic Consent Form

Date: \_\_\_\_\_

Student Name: \_\_\_\_\_

Grade: \_\_\_\_\_

Participating Sport(s): (Circle all that apply)

1<sup>st</sup> Quarter-Baseball, Softball and Competitive Flag Football

2<sup>nd</sup> Quarter-Boys' Soccer and Girls' Volleyball

3<sup>rd</sup> Quarter-Girls' Basketball and Cheerleading

4<sup>th</sup> Quarter-Boys' Basketball, Girls' Soccer and Cheerleading

### Parental Permission:

I/We give permission for \_\_\_\_\_ to participate in middle school 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 the most advanced protective equipment and strict observation 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.

I/We acknowledge that I/We have read and understand this warning.

### Consent for Emergency Care.

Be it known that I, the undersigned parent or guardian of the student above named, do hereby give and grant unto any medical doctor or hospital my consent and authorization to render such aid, treatment or care to said student 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 a middle school sports at Combs Middle School.

I hereby consent for the student named above, to be given medical care by a doctor selected by the school.

IT IS HEREBY understood that the consent and authorization hereby given and granted are continuing and are intended throughout the 2016-2017 school year.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Signature of Student Athlete

\_\_\_\_\_  
Printed Name of Parent/Guardian

\_\_\_\_\_  
Printed Name of Student Athlete



## 2016-2017 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

(The Parent or Guardian should fill out this form with assistance from the student athlete.)

Exam Date: \_\_\_\_\_

Name: \_\_\_\_\_  
Sex: \_\_\_\_\_  
Age: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Grade: \_\_\_\_\_  
School: \_\_\_\_\_  
Sport(s): \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Personal Physician: \_\_\_\_\_  
Hospital Preference: \_\_\_\_\_

In case of emergency, contact:

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Phone (Home): \_\_\_\_\_  
(Work): \_\_\_\_\_  
(Cell): \_\_\_\_\_

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Phone (Home): \_\_\_\_\_  
(Work): \_\_\_\_\_  
(Cell): \_\_\_\_\_

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

1) Has a doctor ever denied or restricted your participation in sports for any reason? **Y** **N**

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

2) Do you have an ongoing medical condition (like diabetes or asthma)?

<input type="checkbox"/>	<input type="checkbox"/>
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3) Are you currently taking any prescription or nonprescription (over-the-counter) medicines or supplements?  
(Please specify): \_\_\_\_\_

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

4) Do you have allergies to medicines, pollens, foods, or stinging insects?  
(Please specify): \_\_\_\_\_

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

5) Does your heart race or skip beats during exercise?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

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 the hospital?

<input type="checkbox"/>	<input type="checkbox"/>
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8) Have you ever had surgery?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

\* 9) Have you ever had an injury (sprain, muscle/ligament tear, tendinitis, etc.) that caused you to miss a practice or game? (If yes, circle affected area in the box below):

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

\* 10) Have you had any broken/fractured bones or dislocated joints?  
(If yes, circle affected area in the box below):

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

\* 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, circle affected area in the box below):

Head <input type="checkbox"/>	Neck <input type="checkbox"/>	Shoulder <input type="checkbox"/>	Upper Arm <input type="checkbox"/>	Elbow <input type="checkbox"/>	Forearm <input type="checkbox"/>
Hand/Fingers <input type="checkbox"/>	Chest <input type="checkbox"/>	Upper Back <input type="checkbox"/>	Low Back <input type="checkbox"/>	Hip <input type="checkbox"/>	Thigh <input type="checkbox"/>
Knee <input type="checkbox"/>	Calf/Shin <input type="checkbox"/>	Ankle <input type="checkbox"/>	Foot/Toes <input type="checkbox"/>		





## 2016-2017 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

(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?	<input type="checkbox"/>	<input type="checkbox"/>
2) Has your child ever had extreme shortness of breath during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
3) Has your child had extreme fatigue associated with exercise (different from other children)?	<input type="checkbox"/>	<input type="checkbox"/>
4) Has your child ever had discomfort, pain or pressure in his/her chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
5) Has a doctor ever ordered a test for your child's heart?	<input type="checkbox"/>	<input type="checkbox"/>
6) Has your child ever been diagnosed with an unexplained seizure disorder?	<input type="checkbox"/>	<input type="checkbox"/>
7) Has your child ever been diagnosed with exercise-induced asthma not well controlled with medication?	<input type="checkbox"/>	<input type="checkbox"/>

Family History Questions: Please tell me about any of the following in your family...

	Y	N
8) Are there any family members who had sudden, unexpected, unexplained death before age 50? (including SIDS, car accidents, drowning, or near drowning)	<input type="checkbox"/>	<input type="checkbox"/>
9) Are there any family members who died suddenly of "heart problems" before age 50?	<input type="checkbox"/>	<input type="checkbox"/>
10) Are there any family members who have unexplained fainting or seizures?	<input type="checkbox"/>	<input type="checkbox"/>
11) Are there any relatives with certain conditions, such as:	<input type="checkbox"/>	<input type="checkbox"/>
Enlarged Heart	<input type="checkbox"/>	<input type="checkbox"/>
Hypertrophic Cardiomyopathy (HCM)	<input type="checkbox"/>	<input type="checkbox"/>
Dilated Cardiomyopathy (DCM)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Rhythm problems:	<input type="checkbox"/>	<input type="checkbox"/>
Long QT Syndrome (LQTS)	<input type="checkbox"/>	<input type="checkbox"/>
Short QT Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Brugada Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT)	<input type="checkbox"/>	<input type="checkbox"/>
Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)	<input type="checkbox"/>	<input type="checkbox"/>
Marfan Syndrome (Aortic Rupture)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack, age 50 or younger	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker or Implanted Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
Deaf at Birth (Congenital Deafness)	<input type="checkbox"/>	<input type="checkbox"/>

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 athlete

Signature of parent/guardian

Date

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

Date:



## 2016-2017 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*
<b>Medical</b>			
Appearance			
Eyes/Ears/ Throat/Nose			
Hearing			
Lymph Nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary †			
Skin			
<b>Musculoskeletal</b>			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/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: \_\_\_\_\_

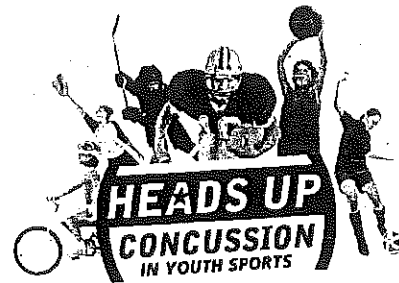
Cleared Without Restriction  
 Not Cleared For:  All Sports  Certain Sports \_\_\_\_\_  Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_

Name of Physician(Print/Type): \_\_\_\_\_ Exam Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of Physician: \_\_\_\_\_, MD/DO/ND/NMD/NP/PA-C/CCSP



# Parent/Athlete Concussion Information Sheet

A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by bump, blow, or jolt to the head or body that causes the head and brain to move rapidly back and forth. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

## WHAT ARE THE SIGNS AND SYMPTOMS OF 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 an athlete reports **one or more** symptoms of concussion listed below after a bump, blow, or jolt to

### Did You Know?

- Most concussions occur *without* loss of consciousness.
- Athletes who have, at any point in their lives, had a concussion have an increased risk for another concussion.
- Young children and teens are more likely to get a concussion and take longer to recover than adults.

the head or body, s/he should be kept out of play the day of the injury and until a health care professional, experienced in evaluating for concussion, says s/he is symptom-free and it's OK to return to play.

SIGNS OBSERVED BY COACHING STAFF	SYMPTOMS REPORTED BY ATHLETES
<p>Appears dazed or stunned</p> <p>Is confused about assignment or position</p> <p>Forgets an instruction</p> <p>Is unsure of game, score, or opponent</p> <p>Moves clumsily</p> <p>Answers questions slowly</p> <p>Loses consciousness (<i>even briefly</i>)</p> <p>Shows mood, behavior, or personality changes</p> <p>Can't recall events <i>prior</i> to hit or fall</p> <p>Can't recall events <i>after</i> hit or fall</p>	<p>Headache or "pressure" in head</p> <p>Nausea or vomiting</p> <p>Balance problems or dizziness</p> <p>Double or blurry vision</p> <p>Sensitivity to light</p> <p>Sensitivity to noise</p> <p>Feeling sluggish, hazy, foggy, or groggy</p> <p>Concentration or memory problems</p> <p>Confusion</p> <p>Just not "feeling right" or "feeling down"</p>

## CONCUSSION DANGER SIGNS

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. An athlete should receive immediate medical attention if after a bump, blow, or jolt to the head or body s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that not only does not diminish, but gets worse
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people or places
- Becomes increasingly confused, restless, or agitated
- Has unusual behavior
- Loses consciousness (*even a brief loss of consciousness should be taken seriously*)

## WHY SHOULD AN ATHLETE REPORT THEIR SYMPTOMS?

If an athlete has a concussion, his/her brain needs time to heal. While an athlete's brain is still healing, s/he is much more likely to have another concussion. Repeat concussions can increase the time it takes to recover. In rare cases, repeat concussions in young athletes can result in brain swelling or permanent damage to their brain. *They can even be fatal.*

It's better to miss one game than the whole season. For more information on concussions, visit: [www.cdc.gov/Concussion](http://www.cdc.gov/Concussion).

### *Remember*

Concussions affect people differently. While most athletes with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer.

## WHAT SHOULD YOU DO IF YOU THINK YOUR ATHLETE HAS A CONCUSSION?

If you suspect that an athlete has a concussion, remove the athlete from play and seek medical attention. Do not try to judge the severity of the injury yourself. Keep the athlete out of play the day of the injury and until a health care professional, experienced in evaluating for concussion, says s/he is symptom-free and it's OK to return to play.

Rest is key to helping an athlete recover from a concussion. Exercising or activities that involve a lot of concentration, such as studying, working on the computer, or playing video games, may cause concussion symptoms to reappear or get worse. After a concussion, returning to sports and school is a gradual process that should be carefully managed and monitored by a health care professional.

\_\_\_\_\_  
Student-Athlete Name Printed

\_\_\_\_\_  
Student-Athlete Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Legal Guardian Printed

\_\_\_\_\_  
Parent or Legal Guardian Signature

\_\_\_\_\_  
Date