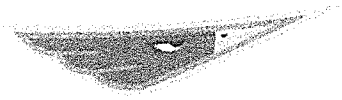

Gililland Athletic Packet
2017-2018

Dear GMS parent and student athlete:

Welcome to a new year of athletics at Gililland Middle School. We are excited knowing that we can be a part of preparing your child with the tools, skills, and knowledge needed on and off of the court to be a GMS and high school athlete. Academics and character in and out of the classroom are a vital part of our sports program. Students must be able to maintain a C or better in all classes throughout the season to be eligible to participate in games. Students must also show good character traits including honesty, respect, and responsibility in and out of the classroom. Athletes are expected to attend all practices in preparation for the upcoming game.

Any student is eligible to tryout for a spot on any of the GMS teams in the fall or spring. A completed sports packet must be on file in the office and students must attend all days of tryouts. Once selected for the team athletes must maintain grades, have good character, and attend all practices. We have worked hard to purchase new sports equipment and uniforms. It will be the responsibility of each GMS athlete to maintain them. Below is a list of sports by season and the replacement cost of uniforms should an athlete lose or not turn one in.

FALL SPORTS	Uniform Replacement Price
Soccer(Coed)	$50.00
Cross Country(Coed)	$50.00
Basketball(Boys)	$90.00
Softball(Girls)	$60.00
Volleyball(Girls)	$50.00
Cheer(Girls)	$50.00

SPRING SPORTS	Uniform Replacement Price
Basketball(Girls)	$90.00
Baseball(Boys)	$50.00

Student Athlete:

By signing below you agree to maintain a C or better throughout the season, attend all practices, and exhibit good character in and out of the classroom. You will be issued a uniform and you agree to maintain it and turn it in at the last game or be charged the fee listed above. Not meeting any of the requirements above could result in no practice/game time, phone calls home, and non participation in GMS events.

Student Name _____ Student Signature _____ Date _____

Parent of Student Athlete:

By signing below you agree to support GMS coaches and your child with the above requirements and expectations.You also agree to ensure your student athlete is picked up from practice by 5:15pm daily. Not doing so could result in no practice/game time.

Parent Name _____ Parent Signature _____ Date _____

Paquete de Deportes de Gililland
2017-2018

Estimados Padres y Estudiantes del Programa de Deportes de GMS:

Bienvenidos a otro nuevo año escolar del programa de deportes de la Escuela Secundaria Gililland (GMS). Estamos muy emocionados de saber que podemos participar para preparar a sus hijos con todas las herramientas y conocimiento que necesitan dentro y fuera de la cancha para ser un atleta en GMS y en la escuela preparatoria. Lo académico y el carácter dentro y fuera del aula son una parte vital de nuestro programa de deportes. Los estudiantes deben ser capaces de mantener una calificación de C o mejor en todas las materias durante la temporada para ser elegibles para participar en los juegos. Los estudiantes también deben mostrar buenos rasgos del carácter tales como, honradez, respeto y responsabilidad dentro y fuera del aula. Se espera que los atletas asistan a todas las prácticas en preparación para el próximo juego.

Todo estudiantes es elegible para hacer la prueba de admisión en cualquier deporte de otoño o primavera. Debe llenar un paquete de deportes y entregar a la oficina de la escuela y asistir todos los días durante las pruebas. Una vez seleccionados para un equipo, deberán mantener sus calificaciones, tener buen carácter y asistir a todas las prácticas. Hemos trabajado arduamente para comprar nuevo equipo y uniformes. Será la responsabilidad de cada atleta de GMS mantenerlos en buenas condiciones. La siguiente es la lista de deportes por temporada y el costo de reemplazo de los uniformes si un atleta lo pierde o no lo regresa.

	Reemplazo del Uniforme
OTOÑO	Precio
Fútbol (mixto)	$50.00
Campo Traviesa (mixto)	$50.00
Baloncesto (niños)	$90.00
Sofbol (niñas)	$60.00
Voleibol (niñas)	$50.00
Porristas (niñas)	$50.00

	Reemplazo del Uniforme
PRIMAVERA	Precio
Baloncesto (niñas)	$90.00
Baloncesto (niños)	$50.00

Estudiante Atleta:
Al firmar abajo, estas de acuerdo en mantener una calificación C o mejor durante la temporada, asistir a todas las prácticas y demostrar un buen carácter dentro y fuera del aula. Te entregarán un uniforme y debes mantenerlo limpio y entregarlo en el último juego o se te cobrará el precio listado abajo. No cumplir con los requisitos anteriores podría tener como resultado no poder practicar/jugar, llamada telefónica a casa y no participar en eventos de GMS.

Nombre del Estudiante _____ Firma del Estudiante _____ Fecha _____

Padre de Familia del Estudiante Atleta:
Al firmar abajo, usted acepta apoyar a los entrenadores de GMS y a su hijo con los requisitos y las expectativas arriba mencionados. Usted también se compromete asegurarse que su estudiante atleta sea recogido después de prácticas a las 5:15pm todos los días. El no hacerlo podría tener como resutlado no poder practicar/jugar.

Nombre del Padre de Familia _____ Firma del Padre de Familia _____ Fecha _____

Tempe Elementary School District # 3
Tempe Athletic Conference (TAC)
Participation Directions & Requirements

Directions:

1. Complete **ALL** information on pages 2-7.
2. At the day of the physical exam **page 8** must be completed and signed by a physician.
3. Turn **ALL** pages into School Athletic Director.

Requirements for Participation:

1. Complete participation packet must be on file.
2. Student must have a physical exam prior to any type of participation.
3. Student must be passing all classes with an average of 70 or better.
4. Student must be enrolled in a Tempe Elementary School District School.
5. Proof of insurance must be provided.
6. Student must be in good standing academically and behaviorally.

For more information or questions - Please contact you schools Athletic Director or the District Athletic Director.

Connolly Middle School
Phone: 480-967-8933, x 4806
AD: Denise Dunwoody
denise.dunwoody@tempeschools.org

Fees College Prep Middle School
Phone: 480-897-6063, x 5206
AD: Erika DeRienzo
erika.derienzo@tempeschools.org

Gilliland Middle School
Phone: 480-966-7114, x 5806
AD: Amy Lamer
amy.lamer@tempeschools.org

Laird School
Phone: 480-941-2440, x 6206
AD: Andre Reyes
andre.reyes@tempeschools.org

Tempe Academy of International Studies
Phone: 480-459-5048, x 6300
AD: David Owen
david.owen@tempeschools.org

Ward Traditional Academy
Phone: 480-491-8871, X 5300
AD: Taime Bengochea
taime.bengochea.tempeschools.org

District PE/Athletic Office
Phone: 480-730-7221
Email: kylee.schneckloh@tempeschools.org

ARIZONA INTERSCHOLASTIC ASSOCIATION
7007 North 18th Street, Phoenix, Arizona 85020-5552
Phone: (602) 385-3810

2017-2018 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.

	Y	N
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 supplements? (Please specify):	☐	☐
4) Do you have allergies to medicines, pollens, foods, or stinging 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 the 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, circle affected area in the box below):	☐	☐
*10) Have you had any broken/fractured bones or dislocated joints? (If yes, circle affected area in the box below):	☐	☐
* 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 ☐ Neck ☐ Shoulder ☐ Upper Arm ☐ Elbow ☐ Forearm ☐
Hand/Fingers ☐ Chest ☐ Upper Back ☐ Low Back ☐ Hip ☐ Thigh ☐
Knee ☐ Calf/Shin ☐ Ankle ☐ Foot/Toes ☐

	Y	N
12) Have you ever had a stress fracture?		
13) Have you 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 medicine?		
19) Were you born without, are you missing, or do you have a nonfunctioning 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) Do you have headaches with exercise?		
26) Have you ever had numbness, tingling, or weakness in your arms or legs after being hit, falling, stingers or burners?		
27) When exercising in the heat, do you have severe muscle cramps or become ill?		
28) Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?		
29) Have you ever been tested for sickle cell trait?		
30) Have you had any problems with your eyes or vision?		
31) Do you wear glasses or contact lenses?		
32) Do you wear protective eyewear, such as goggles or a face shield?		
33) Are you happy with your weight?		
34) Are you trying to gain or lose weight?		
35) Has anyone recommended you change your weight or eating habits?		
36) Do you limit or carefully control what you eat?		
37) Do you have any concerns that you would like to discuss with a doctor?		

Females Only

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

Explain "Yes" Answers Here

ARIZONA INTERSCHOLASTIC ASSOCIATION
7007 North 18th Street, Phoenix, Arizona 85020-5552
Phone: (602) 385-3810

2017-2018 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?		
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?		

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)		
9) Are there any family members who died suddenly of "heart problems" before age 50?		
10) Are there any family members who have unexplained fainting or seizures?		
11) Are there any relatives with certain conditions, such as:		
Enlarged Heart		
Hypertrophic Cardiomyopathy (HCM)		
Dilated Cardiomyopathy (DCM)		
Heart Rhythm problems:		
Long QT Syndrome (LQTS)		
Short QT Syndrome		
Brugada Syndrome		
Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT)		
Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)		
Marfan Syndrome (Aortic Rupture)		
Heart Attack, age 50 or younger		
Pacemaker or Implanted Defibrillator		
Deaf at Birth (Congenital Deafness)		

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:

ARIZONA INTERSCHOLASTIC ASSOCIATION
7007 North 18th Street, Phoenix, Arizona 85020-5552
Phone: (602) 385-3810

2017-2018 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/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

FORM 15.7-B 03/12 NextCare is the preferred partner of the AIA, it is not required you visit NextCare locations for your healthcare needs.

TEMPE ELEMENTARY SCHOOL DIST.#3
CONSENT FOR EMERGENCY

Student Name_____ Student ID#_____ School Name_____

Parents/Guardian Name | Home Phone | Cell Phone | Work Phone

Address | City | Zip | Email

Emergency Contact-Person Who can answer on your behalf for your son/daughter in case of an emergency:

Emergency Contact Name | Phone# | Cell# | Work#

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

Name of Family Physician | Phone# | Date of Current Physical

STATEMENT OF INSURANCE COVERAGE (All students must have some type of insurance.)
Please choose Option 1 or Option 2.

OPTION 1 I affirm that I am the Parent or Legal Guardian of the student listed above. 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 requirement.

I have purchased school insurance (Type)_____/S_____

School Official Signature w/date of application_____

THIS FORM MUST BE SIGNED BY STUDENT AND PARENT OF 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 or hospital my consent and authorization to render such aid, treatment or care to said student as, in judgment of said doctor or hospital, 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 by Tempe Elementary School District.

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 represent and certify that my parent/guardian and I 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.

Parent/Guardian (PRINT)_____Parent/Guardian Signature_____Date_____

Student Name (PRINT)_____Student Name Signature_____Date_____

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: _____

Tempe Athletic Conference Emergency Card

School_____ Date_____

Student_____ Birthdate_____

Address_____ Hm Phone_____

Father_____ Wk Phone_____

Mother_____ Wk Phone_____

Other_____ Phone_____

Doctor_____ Phone_____

Hospital Preference_____ Phone_____

Insurance Co._____

Policy #_____

Health Problems: Circle if Appropriate

Asthma Diabetes Epilepsy Bee Sting Allergies Heart Problems

Other/Specify_____

Medication_____

Consent For Athletic Emergency Care

BE IT KNOWN that in the event I cannot be reached, I, 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 aide, treatment or care to said student as, in the judgment of said doctor or hospital may be required, on an emergency basis, in the even said student should be injured or stricken ill while participating in an interscholastic activity sponsored by the above named school.

IT IS HEREBY understood that the consent and authorization hereby given and granted are continuing, and are intended by me to extend throughout the current school year.

IT IS FURTHER understood that any expenses incurred will be paid for by insurance or the parent of the student. Payment of the expense is not a school responsibility.

_____Yes, I give my consent _____No, I do not give my consent

Signature_____ **Date**_____

Parent or Guardian

Tarjeta de Emergencia de la Conferencia Atlética de Tempe (TAC)

Escuela _____Fecha _____

Estudiante _____Fecha de Nacimiento _____

Dirección _____Tele. del Hogar_____

Nombre del Padre _____Tele._____

Nombre de la Madre _____Tele._____

Otra persona _____Tele._____

Nombre del Doctor _____Tele._____

Hospital _____Tele._____

Seguro Médico _____No. de Póliza _____

Problemas de Salud: (marcar si es aplicable)

Asma Diabetes Epilepsia Picadura de Abeja Alergias Problemas del Corazón

Otro/especificar _____

Medicamentos _____

Autorización para el Cuidado de Emergencia TAC

HAGO SABER que en el caso de que no poder ser localizado/a, yo, el padre de familia/guardián abajo firmante del estudiante arriba nombrado, por medio de la presente otorgo y concedo a cualquier médico u hospital el consentimiento y la autorización para prestar ayuda, tratamiento o cuidado a dicho estudiante con la opinión requerida del médico u hospital en caso de emergencia, en caso de que el estudiante antes mencionado pudiera ser lastimado o se enferma mientras participa en alguna actividad interescolar patrocinada por la escuela antes mencionada.

POR MEDIO DE LA PRESENTE, entiendo que el consentimiento y la autorización concedida y otorgada es continua y previstas por mí para extenderse durante el año escolar en curso.

ESTOY DE ACUERDO que cualquier gasto incurrido serán pagados por el seguro médico o el padre de familia del estudiante. El pago de los gastos no es una responsabilidad de la escuela.

__Sí doy mi consentimiento __No doy mi consentimiento

_____ _____

Firma del Padre de Familia / Guardián Fecha