



# *Pomerene School District #64*

*Educating the Whole Child*

1396 N. Old Pomerene Rd.  
PO Box 7 Pomerene, AZ  
Tel: 520-586-2407  
Fax: 520-586-7724

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Dear Panther Parents:

To help ensure the health and safety of your son or daughter the Pomerene School District requires the following information for participation in interscholastic activities.

1. Athletic Participation Consent/Code Agreement
2. Emergency Medical Treatment Release (please fill out completely with **ALL** insurance information)
3. Parent Code of Ethics
4. Annual Pre-participation Physical Examination (this has replaced the previous Health History Questionnaire.) **THIS FORM MUST BE SIGNED BY A DOCTOR YEARLY.**

If your student does not have health insurance you may purchase a very affordable coverage at [www.studentinsurance-kk.com](http://www.studentinsurance-kk.com). This needs to be purchased before the student can participate.

When ALL of the information is returned and **FILLED OUT COMPLETELY**, the athlete can participate.

Please have the information in this packet completed prior to the student participating in athletic practices or competition.

Sincerely,

Mr. Michael Sherman  
Pomerene School  
Superintendent

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*Pomerene School District is a welcoming school community whose mission is to provide an engaging and safe learning environment, emphasizing quality education and traditional values that prepare students to seize opportunities for success.*

Visit us at: [www.pomereneschool.org](http://www.pomereneschool.org)

Revised 2024



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## **ATHLETIC PARTICIPATION CONSENT**

I hereby give my consent for my student/athlete to participate in organized interscholastic athletics, realizing that even with the best coaching, use of the most advanced protective equipment, and strict observance of rules, injuries, in some cases severe, are still a possibility. I also give my consent for him/her to travel in school-sponsored vehicles operated by school personnel. I agree not to hold the school responsible in case of accident or injury whether it is during team travel, practice, or an interscholastic event provided.

### **ELIGIBILITY TO PARTICIPATE**

To be eligible to compete, students must be passing with a **C** or better all of their subjects at the end of each one-week grading interval. The one-week grading interval runs from 12:01 on Sunday through 7 consecutive 24-hour periods ending on Sunday at midnight. A student has one week to make up any deficiency notice from the time of the first notice.

In order to remain on the team, an athlete is required to practice during his/her period of ineligibility.

**A grade of "C" is the lowest passing grade.** Students who do not meet the above eligibility requirements become academically deficient and will be unable to compete in extracurricular activities until the deficiency is cleared up.

- To be eligible, students must be passing all of their subjects at the end of each one week grading interval. A student has one week to make up any deficiency from the time of the first notice.
- **SEMESTER ELIGIBILITY:** Students must be passing all core classes (Math, Language Arts, Science and Social Studies) at the end of each semester to be eligible to compete in extracurricular activities the following semester.
- A student must be a student in "good standing", i.e. academics, tardies, truancy, discipline.
- A "C" is the lowest passing grade.
- Students who do not meet the above eligibility requirements become academically deficient and will be unable to participate in extracurricular activities until the deficiency is cleared up.
- Academically deficient students will be notified in a manner that will ensure confidentiality, both for pending ineligibility and for the period of ineligibility.
- Coaches and/or sponsors will be advised under the same procedure.
- Support services will be made available to students who become ineligible for extracurricular programs as well as to students notified of pending ineligibility.
- Students whose behavior presents a problem or jeopardizes school discipline may be ineligible for participation in extracurricular activities until such time as their behavior warrants reinstatement.
- The same general statement shall apply for special education students except that such eligibility shall be determined on a case-by-case basis in relationship to the respective students' individual education programs.
- Absences due to athletic participation shall not justify cause for late or incomplete class assignments. Each individual student/athlete is responsible for communicating with their teachers regarding assignments that are due during athletic absences.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student/Athlete Signature

\_\_\_\_\_  
Date

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## **ATHLETIC CODE AGREEMENT** **ATHLETICS**

Interscholastic participants are reminded that they represent their school and community. It is their responsibility to maintain appropriate conduct at all times and to demonstrate behavior that will bring credit to themselves, the school and the community.

Sportsmanship and moral ethics are to be exemplified at all times in relation to other schools and with officials. It is an honor and privilege to participate in interscholastic athletics.

### **RESPONSIBILITY OF PARTICIPANTS**

1. Respect the rules of the school, its' teachers, coaches and administrators.
2. Follow PESD eligibility rules, conference rules, and school rules. You are responsible for maintaining your own eligibility.
3. Strive to perform to your best ability in the classroom.
4. Promote sportsmanship and foster the "Six Pillars of Character" –trustworthiness, respect, responsibility, fairness, caring and good citizenship.
5. Exemplify good behavior, appearance, and conduct at all times.
6. Attend all classes the day of the game.
7. Students are responsible for turning in all equipment and uniforms issued to them immediately after the season is over.
  - I, the undersigned, have read and understand fully the athletic code/athletic participation consent and I agree to abide by it.
  - I, the parent/guardian, have read, understood, and will full support enforcement of this athletic code/athletic participation.

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Parent/Guardian Signature

Date

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Student/Athlete Signature

Date

---

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## **POMERENE ELEMENTARY SCHOOL EMERGENCY MEDICAL TREATMENT RELEASE**

As a parent/guardian of \_\_\_\_\_ I hereby give permission for Pomerene School District personnel to give emergency first-aid treatment and to obtain, if necessary, medical treatment from a doctor and/or hospital. This release may be used during school athletic trips. I agree to the participation of my above-named son/daughter in the program/programs, which they participate in. In addition, I consent to practice sessions and travel to and from the programs.

## **EMERGENCY/MEDICAL INSURANCE STATEMENT**

It is hereby understood that Pomerene School District does not provide medical insurance coverage to students for injuries incurred while participating in athletics. It is further understood that the responsibility for payment of medical expenses lies with the family or their insurance.

Students participating in athletics are **required** to show proof of insurance or purchase individual Student Accident/Health Insurance before they will be allowed to attend any practice session. If your student does not have health insurance you may purchase a very affordable coverage at [www.studentinsurance-kk.com](http://www.studentinsurance-kk.com). This needs to be purchased before the student can participate.

Insurance Company \_\_\_\_\_

Policy Number \_\_\_\_\_

Group Number (If Applicable) \_\_\_\_\_

I, the undersigned, have read and understand fully the Permission to participate, Eligibility policy, Emergency Medical statement and the Medial Insurance Statement and agree to abide by it.

Emergency Phone Numbers (must have ONE)

1. \_\_\_\_\_

2. \_\_\_\_\_

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student/Athlete Signature

\_\_\_\_\_  
Date

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## **Parents Code of Ethics**

- I will encourage good sportsmanship by demonstrating positive support for all players, coaches, and officials at every game, practice or other sports events.
- I will place the emotional and physical well-being of my student/athlete ahead of a personal desire to win.
- I will insist that my student/athlete play in a safe and healthy environment.
- I will support coaches and officials working with my student/athlete, in order to encourage a positive and enjoyable experience for all.
- I will demand a sports environment for my student/athlete that is free of drugs, tobacco and alcohol, and will refrain from their use at all sports events.
- I will remember that the game is for youth – not for adults.
- I will do my very best to make school sports fun for my student/athlete.
- I will ask my student/athlete to treat other players, coaches, fans and officials, with respect regardless of race, sex, creed or ability.
- I promise to help my student/athlete enjoy the sports experience by doing whatever I can, such as being a respectful fan.
- I will expect that the coach be trained in the responsibilities of being a sports coach and that the coach upholds the Coaches' Code of Ethics.
- I will respect the coaches' decisions and will encourage my student/athlete to communicate with the coaches.
- If I disagree with a coach's decision, I will abide by the athletic chain of command.
- I will support the team by cheering in a positive manner.

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Parent/Guardian Signature

Date

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Revised 2024



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

2025-26  
ANNUAL PREPARTICIPATION  
PHYSICAL EVALUATION

NextCare<sup>®</sup>  
URGENT CARE

EXCLUSIVE URGENT CARE  
PARTNER OF THE AIA

(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: \_\_\_\_\_  
Sex Assigned at Birth: \_\_\_\_\_  
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.

Yes No

- 1) Has a doctor ever denied or restricted your participation in sports for any reason?
- 2) List past and current medical conditions:  
\_\_\_\_\_
- 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 had surgery? (Please list): \_\_\_\_\_
- 8) 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 10)
- 9) Have you had any broken/fractured bones or dislocated joints?  
(If yes, check affected area in the box below in question 10):
- 10) 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		

**Yes No**

- 11) Have you ever had a stress fracture?
- 12) Have you ever been told that you have, or have you had an X-ray for atlantoaxial (neck) instability?
- 13) Do you regularly use a brace or assistive device?
- 14) Has a doctor told you that you have asthma or allergies?
- 15) Do you cough, wheeze or have difficulty breathing during or after exercise?
- 16) Have you ever used an inhaler or taken asthma medication?
- 17) Do you have groin or testicular pain, or a painful bulge or hernia in the groin area?
- 18) Were you born without, are you missing, or do you have a non-functioning kidney, eye, testicle or any other organ?
- 19) Have you had infectious mononucleosis (mono) within the last month?
- 20) Do you have any rashes, pressure sores or other skin problems?
- 21) Have you had a herpes skin infection?
- 22) 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")?
- 23) Have you ever had a seizure?
- 24) Have you ever had numbness, tingling or weakness in your arms or legs after being hit, falling, stingers or burners?
- 25) While exercising in the heat, do you have severe muscle cramps or become ill?
- 26) Have you or someone in your family tested positive for sickle cell trait or sickle cell disease?
- 27) Have you been hospitalized or had long-term complication care due to COVID-19?
- 28) Are you happy with your weight?
- 29) Are you trying to gain or lose weight?
- 30) Has anyone recommended you change your weight or eating habits?
- 31) Do you limit or carefully control what you eat?
- 32) Do you have any concerns that you would like to discuss with a doctor?

**Females Only**

**Explain "Yes" Answers Here**

- |  | Yes | No    |
|--|-----|-------|
| 33) Have you ever had a menstrual period?                      |     |       |
| 34) How old were you when you had your first menstrual period? |     | _____ |
| 35) How many periods have you had in the last year?            |     | _____ |





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2025-26  
ANNUAL PREPARTICIPATION  
PHYSICAL EVALUATION



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The physician should fill out this form with assistance from the parent or guardian.)

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

Date of Birth: \_\_\_\_\_

**Patient History Questions: Please Share About Your Child**

**Yes    No**

- 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**

## 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 able 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

## Share Any Notes Related To The Above Section

For more information regarding student-athlete mental health:

Quiet Suffering - A Resource for Student-Athlete Mental Health

[spark.adobe.com/page/lltWyoLpTAp0V/](https://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](https://suicidepreventionlifeline.org)

The Trevor Lifeline

866-488-7386 (for gender diverse youth)

## Family History Questions: Please Share About Any Of The Following In Your Family

		Yes	No
1)	Are there any family members who had sudden/unexpected/unexplained death before age 35? (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:		
		Yes	No
	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 35 or Younger		
	Pacemaker or Implanted Defibrillator		
	Deaf at Birth		

## Explain "Yes" Answers Here

## Additional History

	Yes	No
1) Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff or dip?		
2) Do you drink alcohol or use illicit drugs?		
3) Have you ever taken anabolic steroids or used any other performance-enhancing supplements?		
4) Have you ever taken any supplements to help you gain or lose weight, or improve your performance?		
5) Do you always wear a seatbelt while in a vehicle?		

**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/NP/PA-C/CCSP

\_\_\_\_\_  
 Date

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 % Body Fat (optional): \_\_\_\_\_ Pulse: \_\_\_\_\_  
 BP: \_\_\_\_ / \_\_\_\_ (\_\_\_\_ / \_\_\_\_, \_\_\_\_ / \_\_\_\_)  
 Corrected: Y N  
 Vision: R20/\_\_\_\_ L20/\_\_\_\_  
 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/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 recommendations for further evaluation or treatment of:

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

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

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

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

**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: \_\_\_\_\_



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2025-26

## CONSENT TO TREAT FORM



EXCLUSIVE URGENT CARE  
PARTNER OF THE AIA

### 2025-26 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 designate

#### 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: \_\_\_\_\_