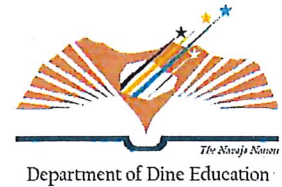




# Winslow Residential Hall, Inc.



**ALL STUDENTS must** submit a complete application for **SY 2021/2022**. The following documents **must** be submitted with your application:

- Student Enrollment Application  
*(NO faxed application will be accepted)*
- Legal Documents  
*(Power of Attorney, Restraining Order, School Suspension)*
- Consent for Release of Information
- Acceptance Letter from WHS & WJHS
- Certificate of Indian Blood (CIB)
- Current Immunization Record
- IEP and/or 504 Documentation, if applicable
- Boundary Map
- COVID-19 Wavier
- Application for Free & Reduced Meal
- Medical Insurance Information
- Physical Examination
- Birth Certificate
- Social Security Card
- Transcript/Report Card
- \$50.00 Room Deposit (**Money Order only**)

**In addition, the following information is what is required prior to enrollment and some of our expectations:**

- Students must be enrolled full-time and provide a class schedule at Winslow High School or Winslow Junior High prior to the approval of residency.
- All student **must** have a 2.5 GPA cumulative or above. An official transcript must be attached to the enrollment application.
- The student **must** have an acceptable attendance at the residential hall and school. If a student fails to maintain their attendance, they can be released from Winslow Residential Hall, Inc.
- Students may enroll up to the age of twenty (20), however students with IEP may be accepted and will be subject to the same policies and procedures of Winslow Residential Hall, Inc. student handbook. Students enrolled at the age of eighteen (18) years of age or during the school year, must sign a wavier of consent.
- Students on juvenile probation **will not** be eligible. If a student is reported to be on juvenile probation, the student will be automatically withdrawn.
- Returning students who were on student contracts **must** be pre-approved by the Homeliving Supervisor and/or Residential Manager prior to enrollment.
- Students are **required** to be present at school and Winslow Residential Hall, Inc. for student count week.
- Students with special needs will be considered for enrollment upon review of their medical history. If enrolled, the staff must be aware of all medication and any condition that may arise in an emergency.

**If you should have any questions or concerns regarding this application, please contact our office at (928) 289-4488.**

# Student Enrollment Application

Type of School: Residential  
\_\_\_\_\_ Returning Student  
\_\_\_\_\_ New Student

School Year: \_\_\_\_\_  
Grade: \_\_\_\_\_ 7th \_\_\_\_\_ 10th  
\_\_\_\_\_ 8th \_\_\_\_\_ 11th  
\_\_\_\_\_ 9th \_\_\_\_\_ 12th



## IDENTIFICATION

Student's Name: \_\_\_\_\_  
Last, First, Middle

Gender: \_\_\_\_\_ Male \_\_\_\_\_ Female

Home Address: \_\_\_\_\_

Social Security No.: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Date Year

P.O. Box: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Tribal Affiliation: \_\_\_\_\_

Enrollment No.: \_\_\_\_\_

Religious Affiliation: \_\_\_\_\_

Degree (per CIB): 4/4 3/4 1/2 1/4

Language: Navajo Hopi English Other: \_\_\_\_\_  
*Dominant Language spoken in the home (circle one)*

Other: \_\_\_\_\_

Is your child eligible for special needs service?

NO  YES

What is their disability? \_\_\_\_\_

NO  YES

Does your child have a current Individual Education Plan (IEP)?

NO  YES

\* Please attach a copy of your child's IEP.

## BACKGROUND INFORMATION

Has your child been arrested?

NO  YES

Is your child on probation?

NO  YES

Has your child ever had drug/alcohol treatment, aftercare services or counseling?

NO  YES

Has your child had treatment, hospitalized or counseled for other issues?

NO  YES

If you answered YES to any of the above questions, please explain: \_\_\_\_\_

## EMERGENCY CONTACT (other than parents/guardians)

Contact Name: \_\_\_\_\_

Phone No.: \_\_\_\_\_

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

Relationship: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Phone No.: \_\_\_\_\_

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

Relationship: \_\_\_\_\_

## SCHOOL(S) PREVIOUSLY ATTENDED *(most recent first)*

School Name: _____	Dates Attended: _____
Reason for Leaving: _____	Grade: _____
_____	
School Name: _____	Dates Attended: _____
Reason for Leaving: _____	Grade: _____

## PARENT INFORMATION

Student resides with (circle one):                      Parents      Mother      Father      \*Legal Guardian

\*Grandparents      Mother/Step-Father      Father/Step-Mother

*\*Must present legal guardianship or power of attorney documents*

Mother's Name: \_\_\_\_\_

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

City                      State                      Zip Code

Father's Name: \_\_\_\_\_

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

City                      State                      Zip Code

Tribal Affiliation: \_\_\_\_\_

Census No.: \_\_\_\_\_

Living                       Deceased

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Mobile No.: \_\_\_\_\_

Work No.: \_\_\_\_\_

Email: \_\_\_\_\_

Tribal Affiliation: \_\_\_\_\_

Census No.: \_\_\_\_\_

Living                       Deceased

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Mobile No.: \_\_\_\_\_

Work No.: \_\_\_\_\_

Email: \_\_\_\_\_

## SILBING(S) INFORMATION

Name: _____	Age: _____	School Attending: _____
Name: _____	Age: _____	School Attending: _____
Name: _____	Age: _____	School Attending: _____
Name: _____	Age: _____	School Attending: _____

I am legally responsible for my child and hereby apply for his/her admission to Winslow Residential Hall, Inc. I understand that the residential hall may request additional information before my child is enrolled.

\_\_\_\_\_

Print Name

\_\_\_\_\_

Signature of Parent/Guardian

\_\_\_\_\_

Date



# STUDENT CHECK-OUT POLICY

Student's Name: \_\_\_\_\_  
Last First Middle

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

## WEEKLY CHECK-OUT POLICY

Student attendance is very important to us, therefore we discourage parents/guardians and family members from checking out your child(ren) during school hours unless prior arrangements have been made with the residential hall.

***You're expected to pick up your child no later than 6:00pm (MST) on Friday***, unless prior and specific arrangements have been made with the residential. In the event you are unable to be on time, you are required to call and inform the residential hall of the projected time of arrival.

Please remember that all authorized adults that check out your child(ren) **must** be a blood relative and over the age of twenty-five (25).

On Fridays, we ask that you **not** check-out your child(ren) until school is dismissed after 2:30pm. Any questions regarding this policy should be addressed to the administration office for clarification.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date

Winslow Residential Hall, Inc.

600 N. Alfred Ave., Winslow, AZ 86047 | Telephone: (928) 289-4488 Fax: (928) 289-2821

# AUTHORIZATION

Student's Name: \_\_\_\_\_  
Last First Middle

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

## STUDENT TRAVEL

I authorize for my child to travel on trips that are sponsored and endorsed by Winslow Residential Hall, Inc., using Winslow Residential Hall Inc., transportation.

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

\_\_\_\_\_  
Date

## MEDICAL

In case of an emergency or illness of my child, and I cannot be contacted immediately, I authorize Winslow Residential Hall Inc., staff to transport my child to the nearest Indian Health clinic, non-profit hospital or private hospital for medical treatment.

\_\_\_\_\_  
Designated Hospital No. Name of Insurance Policy No.

My child (does) or (does not) have special medical condition(s):

\_\_\_\_\_  
\_\_\_\_\_

My child is being treated for: \_\_\_\_\_ by \_\_\_\_\_  
(Type of Medical Condition) (Physician's Name)  
at \_\_\_\_\_  
(Location of Treatment)

Other information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
Date

Winslow Residential Hall, Inc.

600 N. Alfred Ave., Winslow, AZ 86047 | Telephone: (928) 289-4488 Fax: (928) 289-2821

# GUIDANCE COUNSELING SERVICES

Student's Name: \_\_\_\_\_ D. O. B.: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Last First Middle Month Date Year

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

Gender:  Female  Male

Phone No.: \_\_\_\_\_

Dear Parent/Guardian,

The counseling and guidance services that will be provided by Winslow Residential Hall Inc., Counselor are designed to supplement the counseling services of the Winslow Unified School District counseling staff. Winslow Residential Hall Inc., Counselor is certified to provide services in the area of career readiness, academic, social and planning skills, decision-making skills, and consequences and behavior management.

Winslow Residential Hall Inc., Counselor will be the contact person with Winslow Indian Health Care Center and other related agencies if there are referral needs for additional counseling services for your child. Winslow Residential Hall Inc., Counselor training and responsibilities are tied to academic success. Winslow Residential Hall Inc., Counselor is not a psychologist or therapist.

I, **DO** give consent for my child to participate in counseling services provided by Winslow Residential Hall Inc.

I, **DO NOT** give consent for my child to participate in the counseling services provided by Winslow Residential Hall Inc.

*According to the Bureau of Indian Affairs (BIA) 25 CFR Subpart 36.91: parents/guardians may opt out of any non-emergency behavioral health services by **submitting a written request**.*

If you **DO NOT** give Winslow Residential Hall Inc., consent for counseling, please provide a reason:

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

\_\_\_\_\_  
Date

**Winslow Residential Hall, Inc.**

600 N. Alfred Ave., Winslow, AZ 86047 | Telephone: (928) 289-4488 Fax: (928) 289-2821

# STUDENT ASSISTANCE PROGRAM CONSENT

Student's Name: \_\_\_\_\_  
Last First Middle

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

Dear Parent/Guardian,

The counseling department at Winslow Residential Hall Inc., will be inviting all students to participate in a peer support group. This is a **voluntary support group** that is part of our Student Assistance Program (SAP).

The goal of these groups are to increase students' self esteem, decision-making, life skills, communication skills, problem solving strategies, building self-worth and confidence, and help promote and encourage healthy lifestyles. It is our belief that building these personal skills help students prepare and effectively cope with peer pressure and school related stresses and other issues they may be facing.

Peer support groups meet weekly and are scheduled in the evenings while students are on campus and last not longer than one (1) hour. Facilitators are specially trained residential advisors and staff. The training model is used by Winslow Unified School District.

If you would like further information or have any questions, please contact the Winslow Residential Counseling Department at (928) 289-4488/2379.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date

Winslow Residential Hall, Inc.

600 N. Alfred Ave., Winslow, AZ 86047 | Telephone: (928) 289-4488 Fax: (928) 289-2821



# PHOTO AUTHORIZATION

Student's Name: \_\_\_\_\_  
Last First Middle

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

I, \_\_\_\_\_ parent/guardian of \_\_\_\_\_ hereby  
Parent/Guardian Name Student Name  
grant permission to Winslow Residential Hall Inc., to take and/or use photos of my child to use in news release and/or educational material.

I agree that my child's name and identity may be revealed in descriptive text or commentary in connection with the image(s) and I authorize the use of these images without compensation to Winslow Residential Hall Inc. All negatives, prints, digital reproductions shall be property of Winslow Residential Hall Inc.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date

I do not grant permission to Winslow Residential Hall Inc., to take/or use photos of my child in any Winslow Residential Hall Inc., sponsored news release and/or educational material.

Winslow Residential Hall, Inc.

600 N. Alfred Ave., Winslow, AZ 86047 | Telephone: (928) 289-4488 Fax: (928) 289-2821

## **WINSLOW RESIDENTIAL HALL, INC. INTERNET USE AND AGREEMENT POLICY**

Before a student, parent and/or employee may access the Winslow Residential Hall, Inc's (WRHI) technology resources, the individual must have a signed and dated user agreement on file. The user agreement of a student *who is a minor* must also have the signature of a parent or guardian who has read and will uphold this agreement.

### **PURPOSE:**

Winslow Residential Hall, Inc. is pleased to continue offering access to the internet to their students, employees, and parents. The internet is provided to support access to global information to increase career development, research, homework assistance, and communication.

The WRHI has the right to set reasonable restrictions on any material a student can access or post. This policy is set forth to protect the students, parents, and staff of WRHI. Inappropriate use can increase the risks of virus attacks, endangers the network systems and service, legal copyright violation, student privacy and unacceptable risks to students.

### **SCOPE:**

This policy will be relevant and applied to all the students, parents, and employees using the Information Technology (IT) system at WRHI. This policy also applies to all equipment owned or leased by WRHI and all related equipment. The internet users accept the responsibilities of adhering to high standards of conduct and the terms and conditions set forth in all parts of this policy.

### **TERMS OF USE:**

Only the authorized users who have signed the user agreement shall have computer access, the agreement shall remain in effect for the remainder of the school year.

### **TERMS AND CONDITIONS:**

1. All internet, tablet, or computer equipment use shall be consistent with the purpose, goals, policies and rules of the WRHI. It is imperative that users of the IT system conduct themselves in a responsible, ethical, moral, and polite manner, as well as following all rules for behavior and communications.
2. The users agree to abide by the general accepted rules of the WRHI Student Handbook as approved by the Governing Board. Furthermore, WRHI is governed by the BIE policies located at [http://enan.bia.edu/site\\_res\\_view\\_folder.aspx?id=71dd2af0-a19a-4ceb-a11d-e2dad6ceace2](http://enan.bia.edu/site_res_view_folder.aspx?id=71dd2af0-a19a-4ceb-a11d-e2dad6ceace2)
3. Accessing or transmitting of immoral, obscene, pornographic, profane, lewd, vulgar, rude, defaming, harassing, threatening, disrespectful, or otherwise inappropriate images or information is strictly prohibited.
4. Any attempt to bypass school internet security (e.g. bypassing proxies or "hacking" servers or work stations), and/or installing of any type of software is forbidden.
5. Any destruction, defacement, theft, unauthorized altering of WRHI's computer system, attempting illegal access to or from WRHI computer systems, and intentional spreading of a computer virus or similar programs is unacceptable, and will not be tolerated.

6. The users agree to abide by all patent, trademark, trade name, and copyright laws. Plagiarism in any form will not be tolerated. All sources must be cited.
7. ***The users will not access any chat rooms, instant messaging, and websites such as: Facebook, You Tube, Twitter, and/or any other similar websites, as these sites have inappropriate content that violates this policy. In addition, users are prohibited from downloading music to their IPOD or to any other devices.***
8. Users are prohibited from providing information about themselves or others over the internet including social security number, credit card information, passwords, usernames, and/or other personal information.
9. All users agree NOT to use any computing resources for commercial purposes, product advertising, political lobbying, or political campaigning.

### **PRIVILEGE:**

The use of the IT system within the WRHI is a ***privilege, not a right***. The information produced from internet access, tablet, or computer use shall be deemed the property of WRHI. All users agree and consent to allow WRHI staff to review any and all files, data and messages to ensure that users are using the system responsibly at any time with or without notice.

### **SECURITY:**

Internet users may encounter materials that are controversial or inappropriate or offensive. WRHI has taken precautions to restrict access to inappropriate materials through a filtering and monitoring system. However, it is impossible on a global Internet to control access to all data which a user may discover. It is the user's responsibility not to initiate access to such material, and any site or material that is deemed controversial. These activities shall be reported immediately to the appropriate administrator. WRHI expressly disclaims any obligation to discover all violations of inappropriate Internet access.

### **PENALTIES FOR IMPROPER USE:**

1. Unacceptable use or violations of this policy may result in restricting Internet use or use of any or all computers. WRHI administrators may refuse to reinstate privileges to use the IT system for the remainder of the student's enrollment at WRHI.
2. The WRHI may also take other disciplinary actions in certain circumstances. In some instances inappropriate computer and internet use violates state and/or federal laws and may result in criminal prosecution or juvenile court action.

### **DISCLAIMER OF ALL WARRANTIES:**

WRHI makes no warranties of any kind, whether expressed or implied, for the services provided in connection with use of the internet or computer equipment. WRHI will not assume the responsibility or liability for any loss of data resulting from delays, non-deliveries or service interruptions caused by negligence or errors indirectly or directly. WRHI specifically denies any responsibility for the accuracy of quality of information obtained through its services.

# INTERNET USE AGREEMENT

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_  
Last First Middle

I understand and will abide by the provisions and conditions indicated. I understand that any violations of the internet use policy may result in disciplinary actions and the revocations of my use of the IT system at Winslow Residential Hall Inc.

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Student Name

Signature: \_\_\_\_\_

*\* The user agreement of a student who is a minor must also have the signature of a parent/guardian who has read and will uphold this agreement.*

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## Parent/Guardian Consent

As the parent/guardian of the above-named student, I have read the Winslow Residential Hall Inc., Internet Use and Agreement policy and understand it. I understand that its impossible for Winslow Residential Hall Inc., to restrict access to all controversial materials, however I will not hold Winslow Residential Hall, Inc., responsible for materials by use of the IT system. I also agree to report any misuse of the IT system to a Winslow Residential Hall Inc., administrator.

I accept full responsibility and hereby give my permission to have my child use Winslow Residential Hall Inc., IT system.

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent/Guardian Name

Signature: \_\_\_\_\_

Winslow Residential Hall, Inc.

600 N. Alfred Ave., Winslow, AZ 86047 | Telephone: (928) 289-4488 Fax: (928) 289-2821

# MEDICAL INFORMATION

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_  
Last First Middle

Which of the following conditions is your child currently being treated or have been treated for in the past (please check all that apply):

- |                                                      |                                                  |                                                   |
|------------------------------------------------------|--------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Heart Disease/Murmur/Angina | <input type="checkbox"/> Neurological Problems   | <input type="checkbox"/> Thyroid Problems         |
| <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> Psychiatric Care        | <input type="checkbox"/> Seasonal Allergies       |
| <input type="checkbox"/> Heartburn (Relfux)          | <input type="checkbox"/> Kidney/Bladder Problems | <input type="checkbox"/> Ear/Hearing Problems     |
| <input type="checkbox"/> Swollen Ankles              | <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Seizures                 |
| <input type="checkbox"/> Lung Problems/Cough/Asthma  | <input type="checkbox"/> Ulcers/Collitis         | <input type="checkbox"/> Headaches/Migraines      |
| <input type="checkbox"/> Sinus Problems              | <input type="checkbox"/> High Cholesterol        | <input type="checkbox"/> Depression/Anxiety       |
| <input type="checkbox"/> Tonsillitis                 | <input type="checkbox"/> Low Blood Pressure      | <input type="checkbox"/> Diabetes                 |
| <input type="checkbox"/> Eye disorder/Glaucoma       | <input type="checkbox"/> Anemia/Blood Problems   | <input type="checkbox"/> Liver Problems/Hepatitis |
| <input type="checkbox"/> Stroke                      | <input type="checkbox"/> Shortness of Breath     | <input type="checkbox"/> Cancer                   |

Please describe any current or past medical treatment not listed above:

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Please list your child's past surgeries:

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Allergies:

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Is your child allergic to penicillin or any other drugs?  Yes  No

Please list:

---

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\_\_\_\_\_  
Name of Insurance Name of Policy Holder Policy No.

\_\_\_\_\_  
Insurance Phone No. Policy Holder Signature Date

## Winslow Residential Hall, Inc.

600 N. Alfred Ave., Winslow, AZ 86047 | Telephone: (928) 289-4488 Fax: (928) 289-2821



# DATABASE

Winslow Indian Health Care Center  
500 North Indiana Avenue  
Winslow, Arizona 86047

NAME (LAST, FIRST, MIDDLE)			OTHER NAMES USED (MAIDEN NAME)			WIHCC NO.		SEX M F			
BIRTH DATE	PLACE OF BIRTH (CITY, STATE)			SOCIAL-SECURITY NO.		MARITAL STATUS		INTERNET Y N			
CURRENT COMMUNITY		DATE MOVED		LOCATION OF HOME (DIRECTIONS TO YOUR HOME, ETC. PLEASE BE SPECIFIC.)							
MAILING ADDRESS				CITY/STATE			ZIP CODE				
HOME PHONE NUMBER			MESSAGE PHONE NUMBER			WORK PHONE NUMBER					
INDIAN BLOOD QUANTUM		TRIBE		DEGREE		CENSUS NUMBER		CIB Y N			
		OTHER TRIBE		DEGREE		RELIGION					
FATHER'S NAME			CITY OF BIRTH		STATE OF BIRTH						
MOTHER'S MAIDEN NAME			CITY OF BIRTH		STATE OF BIRTH						
EMPLOYER (IF APPLICABLE)				SPOUSE'S EMPLOYER (IF APPLICABLE)							
EMPLOYER'S ADDRESS				SPOUSE'S EMPLOYER'S ADDRESS							
EMPLOYER PHONE NUMBER				SPOUSE'S EMPLOYER PHONE NUMBER							
IF YOU ARE UNEMPLOYED, PLEASE GIVE SOURCE OF INCOME											
UNEMPLOYMENT		RETIREMENT		SSI		SSB		WELFARE		OTHER	
NAME OF EMPLOYER (FATHER) 18 & UNDER			EMPLOYER ADDRESS			EMPLOYER TELEPHONE NUMBER					
NAME OF EMPLOYER (MOTHER) 18 & UNDER			EMPLOYER ADDRESS			EMPLOYER TELEPHONE NUMBER					
EMERGENCY CONTACT PERSON				NEXT OF KIN CONTACT PERSON							
RELATIONSHIP		PHONE NUMBER			RELATIONSHIP		PHONE NUMBER				
ADDRESS				ADDRESS							
<b>HEALTH INSURANCE INFORMATION</b>											
DO YOU HAVE MEDICARE COVERAGE?			YES	NO	DO YOU HAVE RAILROAD RETIREMENT COVERAGE?			YES	NO		
DO YOU HAVE AHCCCS (MEDICAID)?			YES	NO	DO YOU HAVE PRIVATE INSURANCE COVERAGE?			YES	NO		
MILITARY SERVICE?	YES	NO	BRANCH		CLAIM NUMBER		ENTRY DATE		SEPARATION DATE		
VIETNAM VETERAN?			YES	NO	SERVICE CONNECTED?			YES	NO		
HOUSEHOLD INFORMATION: How many family members in your household – including children?											
<b>PLEASE READ AND SIGN CAREFULLY</b>											
I authorize Winslow Indian Health Care Center to release any medical information or records necessary to process my Medicare, Medicaid or other insurance claims. I authorize my insurance company to pay medical benefits directly to Winslow Indian Health Care Center. If I am a non-beneficiary, I understand co-payments and deductibles will be requested at the time of service. I understand that I will be responsible for all costs if my account should be turned over to collections.											
SIGNATURE OF PATIENT, PARENT OR GUARDIAN						DATE					





## Winslow Residential Hall, Inc.

600 N. Alfred Ave., Winslow, AZ 86047

Telephone: (928) 289-4488;2379 Fax: (928) 289-2821/2258

### **PARENTAL PERMISSION, ACKNOWLEDGEMENT OF HAZARDS, ASSUMPTION OF RISK AND WAIVER OF LIABILITY AGREEMENT**

**BY SIGNING AND RETURNING THIS DOCUMENT, YOU ARE GIVING UP SUBSTANTIAL LEGAL RIGHTS. THEREFORE, YOU ARE ADVISED TO READ THIS AGREEMENT CAREFULLY BEFORE SIGNING AND RETURNING IT.**

#### **DISCLOSURE**

Our communities are facing a pandemic related to the outbreak of the 2019 novel coronavirus and Covid-19 ("Coronavirus"). Despite Federal, State, and Tribal governments taking measures to protect public health and slow the spread of Coronavirus, the virus remains a problem and threatens the health and well-being of our students, staff, and families, and can lead to illness, disability, and death. Winslow Residential Hall, Inc. ("WRHI") is striving to implement policies, procedures, and practices to prevent the spread of the virus. However, WRHI cannot guarantee that the virus does not exist or will not spread in our facilities and during our activities. In order to address this situation, WRHI is requiring students and their parents/guardians to follow certain procedures and acknowledge certain risks.

#### **PERMISSION, ACKNOWLEDGEMENT, ASSUMPTION OF RISK AND WAIVER**

In consideration for permitting my child \_\_\_\_\_ ("the Student") to attend and reside at WRHI and participate in all WRHI-related activities (collectively "the Activity") and other good and valuable consideration the receipt and sufficiency of which are hereby acknowledged, I hereby agree to the following on behalf of myself, the Student, my spouse, heirs, executors, administrators, representatives, and/or assigns (collectively "Releasers"):

\_\_\_\_\_ 1. I am familiar with Coronavirus, including its contagious nature, symptoms, health risks, and means by which it is spread and contracted by humans. I am also familiar with the Activity and understand that participation in the Activity might result in exposure to Coronavirus. Nonetheless, I give permission for Student to participate in the Activity.

\_\_\_\_\_ 2. I acknowledge that the risk of exposure to and contracting Coronavirus cannot be eliminated or even substantially reduced without jeopardizing the essential qualities of the Activity. Nevertheless, I accept those risks and assume full responsibility for the health, safety, and well-being of the Releasers.

\_\_\_\_\_ 3. The Releasers, including the Student, agree to abide by all instructions and protocols implemented by WRHI representatives pertaining to Coronavirus, including but not limited to rules and regulations regarding personal protective equipment such as masks and face shields, hygiene, social distancing, temperature checks, and physical examinations. The Releasers further agree to report to the WRHI Homeliving Supervisor any activity that is contrary to such instructions or is potentially or actually dangerous because it promotes the spread of Coronavirus. I understand that any person, including Student, may be precluded from the Activity if it is determined that the person is not following instructions, protocols, rules, regulations, and best practices designed to slow the spread of Coronavirus.

\_\_\_\_\_ 4. I certify that Student is in good health and fully capable of participating in the Activity. I certify further that Student has not tested positive for COVID-19, has not exhibited any symptoms of COVID-19 (including without limitation fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle





## Winslow Residential Hall, Inc.

600 N. Alfred Ave., Winslow, AZ 86047

Telephone: (928) 289-4488;2379 Fax: (928) 289-2821/2258

or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, and/or diarrhea), and to the best of my knowledge, does not have COVID-19 and has not been exposed to anyone who has COVID-19 or symptoms of COVID-19 within the past 14 calendar days.

\_\_\_\_ 5. I agree to check Student for symptoms of COVID-19 each week before weekly check-in to WRHI. I agree further that if Student exhibits symptoms of COVID-19 or is exposed to anyone who has COVID-19 or symptoms of COVID-19, I will have Student tested for COVID-19.

\_\_\_\_ 6. I agree that if Student contracts COVID-19, tests positive for COVID-19, or exhibits symptoms of COVID-19, or is exposed to anyone who has COVID-19 or symptoms of COVID-19, I will (a) voluntarily, fully, and honestly notify the WRHI Homeliving Supervisor and (2) voluntarily keep Student out of WRHI and the Activity until it is medically determined that Student does not have COVID-19.

\_\_\_\_ 7. I agree that WRHI may take reasonable measures, including temperature checks and physical examinations, to check Student for symptoms of COVID-19.

\_\_\_\_ 8. I understand that any person, including Student, may be precluded from WRHI and the Activity if it is determined that the person is showing symptoms of COVID-19, has COVID-19, has tested positive for COVID-19, and/or has been exposed to a person showing symptoms of COVID-19 or who has COVID-19. The person may be permitted to return to the Activity after it is medically confirmed that the person does not have COVID-19.

\_\_\_\_ 9. I, on behalf of the Releasors, hereby voluntarily release, forever discharge, agree to hold harmless and indemnify, and agree not to sue WRHI, its Board Members, employees, volunteers, agents, attorneys, and all other persons and entities (collectively "Releasees") from and for any and all liability, claims, demands, actions, or rights of action, which are related to, arise out of, or are in any way connected with Coronavirus, including without limitation claims arising out of Student's exposure to or contracting of Coronavirus and claims arising from Releasee's negligent acts or omissions.

\_\_\_\_ 10. If any provision of this document is declared void or unenforceable, such provision shall be deemed severed from this document which shall otherwise remain in full force and effect. This document shall be binding upon and inure to the benefit of the parties hereto and their respective heirs, assigns and successors-in-interest. This document contains the entire understanding between and among the parties and supersedes any prior understandings and agreements among them respecting the subject matter of this document.

\_\_\_\_ 11. I have carefully read this document and fully understand its content. I am aware that this document is a parental permission, acknowledgment of hazards, assumption of risks, waiver of liability, an agreement not to sue, and a contract between me and the School. I sign this document voluntarily, knowingly, and intelligently.

\_\_\_\_\_  
Parent/Guardian Print Name

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

\_\_\_\_\_  
Date

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



## Winslow Residential Hall, Inc.

600 N. Alfred Ave., Winslow, AZ 86047

Telephone: (928) 289-4488;2379 Fax: (928) 289-2821/2258

### STUDENT AGREEMENT

I, \_\_\_\_\_, agree that while attending and residing at Winslow Residential Hall, Inc. and participating in Winslow Residential Hall, Inc. activities, I will follow all instructions and protocols regarding Coronavirus, including rules and regulations regarding personal protective equipment such as masks and face shields, hygiene, social distancing, temperature checks, and physical examinations.

\_\_\_\_\_  
Student Signature

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

Acknowledge that all necessary is true and correct for \_\_\_\_\_, I understand that this

Student Name

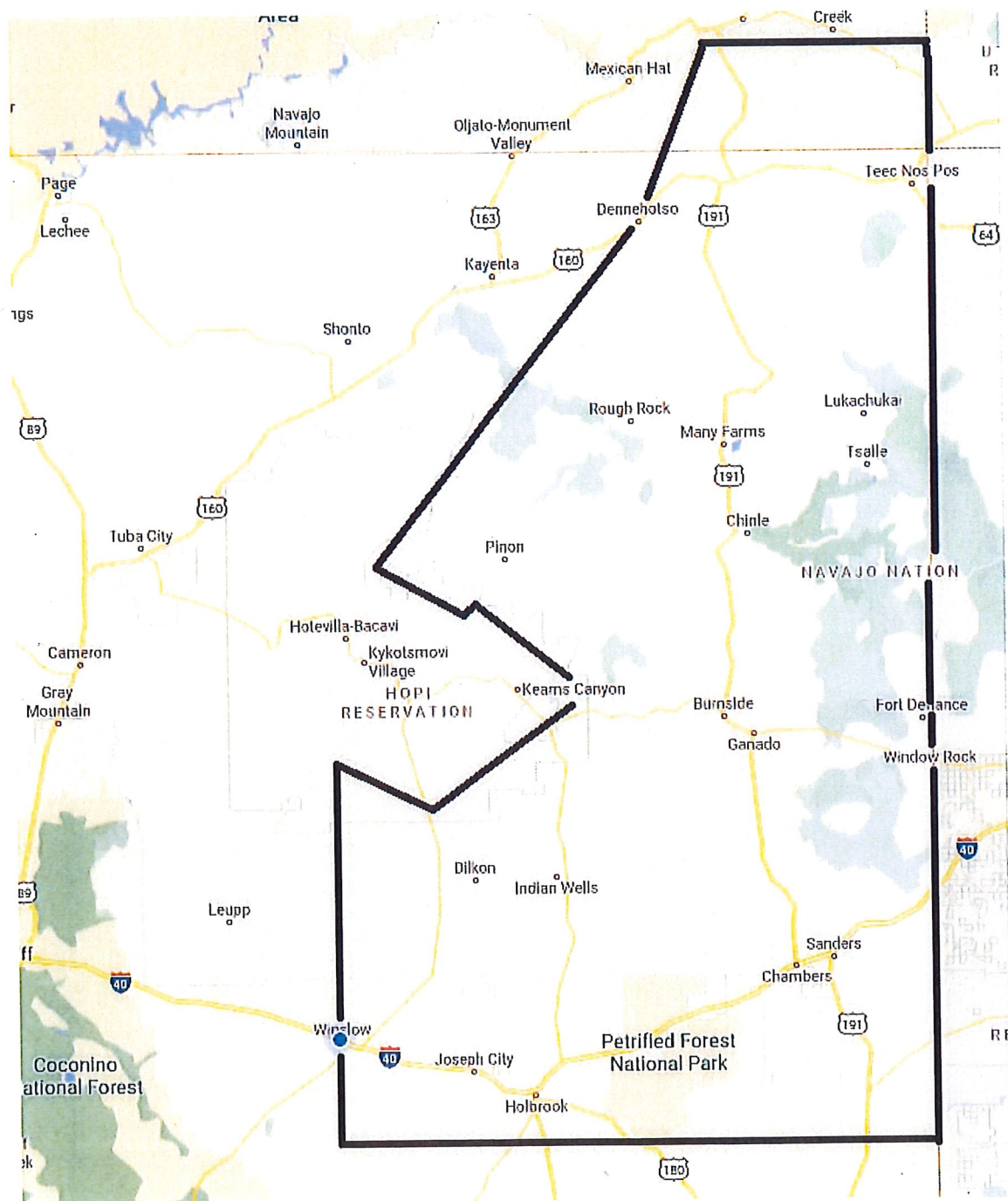
Information is being furnished for the receipt of federal funds that school officials may verify the information on the application, and that deliberate misrepresentation of any information may subject me to prosecution under applicable state and federal laws.

Signature of Parent/Guardian

Date

Physical Location: \_\_\_\_\_ School Year: \_\_\_\_\_

Please put an "X," where the student lives:





**INSTRUCTIONS**

**Sources of Income**

Sources of Income for Children		
Type of Income	Examples	
Earnings from work	A child has a job where they earn a salary or wages.	
Social Security - Disability payments	A child is blind or disabled and receives Social Security benefits.	
- Survivor Benefits	A parent is disabled, retired, or deceased and their child receives social security benefits.	
Income from persons <i>outside</i> the household	A friend or extended family member <i>regularly</i> gives a child spending money.	
Income from any other source	A child receives income from a private pension fund, annuity or trust.	

Sources of Income for Adults		
Earnings from Work	Public Assistance/ Alimony/Child Support	Pensions/Retirement/All Other Income
<ul style="list-style-type: none"> <li>- Salary, wages, cash bonuses</li> <li>- Net income from self-employment (farm or business)</li> </ul>	<ul style="list-style-type: none"> <li>- Unemployment benefits</li> <li>- Workers Compensation</li> <li>- Supplemental Security Income (SSI)</li> </ul>	<ul style="list-style-type: none"> <li>- Social Security (including railroad retirement and black lung benefits)</li> <li>- Private Pensions or disability</li> <li>- Regular income from trusts or estates</li> </ul>
<p><b>If you are in the U.S. Military:</b></p> <ul style="list-style-type: none"> <li>- Basic pay and cash bonuses (<i>do not include combat pay, FSSA, or privatized housing allowances</i>)</li> </ul>	<ul style="list-style-type: none"> <li>- Cash Assistance from State or local government</li> <li>- Alimony payments</li> <li>- Child support payments</li> <li>- Veteran's benefits</li> <li>- Strike benefits</li> </ul>	<ul style="list-style-type: none"> <li>- Annuities</li> <li>- Investment Income</li> <li>- Earned Interest</li> <li>- Rental Income</li> <li>- Regular cash payments from outside household</li> </ul>
<ul style="list-style-type: none"> <li>- Allowances for off-base housing, food and clothing</li> </ul>		

**OPTIONAL**

**Children's Racial and Ethnic Identities**

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for free or reduced price meals.

**Ethnicity (check one):**

- Hispanic or Latino       Not Hispanic or Latino

**Race (check one or more):**

- American Indian or Alaskan Native     Asian     Black or African American     Native Hawaiian or Other Pacific Islander     White

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

This institution is an equal opportunity provider.

## CONSENT FOR SHARING INFORMATION WITH OTHER PROGRAMS

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Dear Parent/Guardian:

The information you gave on your Free and Reduced-Price School Meals Application may be shared with other programs for which your children may qualify. For the following programs, we must have your permission to share your information. Sending in this form will not change whether your children get free or reduced-price meals.

---

No! I **DO NOT** want information from my Free and Reduced-Price School Meals Application shared with any of these programs.

---

Yes! I **DO** want school officials to share information from my Free and Reduced-Price School Meals Application with **Arizona Department of Education**.

Yes! I **DO** want school officials to share information from my Free and Reduced-Price School Meals Application with **Nutrikids (POS system)**.

If you checked yes to any or all the boxes above, fill out the form below. Your information will be shared only with the programs you checked.

Child's Name: \_\_\_\_\_ School: \_\_\_\_\_

Child's Name: \_\_\_\_\_ School: \_\_\_\_\_

Child's Name: \_\_\_\_\_ School: \_\_\_\_\_

Child's Name: \_\_\_\_\_ School: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

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

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For more information, you may call **Marilyn June** at **928-289-4488 ext 107** or e-mail at **[mjune@wrhinc.org](mailto:mjune@wrhinc.org)**.

Please return this form with your school meal application: **600 N Alfred Ave., Winslow, Az. 86047** by **July 29, 2021**.

*This institution is an equal opportunity provider.*



## 2021-22 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?	<input type="checkbox"/>	<input type="checkbox"/>
2) Do you have an ongoing medical conditional (like diabetes or asthma)?	<input type="checkbox"/>	<input type="checkbox"/>
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 stringing 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): <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> A Heart Murmur <input type="checkbox"/> High Cholesterol <input type="checkbox"/> A Heart Infection		
7) Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>
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, check affected area in the box below in question 11)	<input type="checkbox"/>	<input type="checkbox"/>
10) Have you had any broken/fractured bones or dislocated joints? (If yes, check affected area in the box below in question 11):	<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, check affected area in the box below):	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 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"/> Lower 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		



	Y	N
12) Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>
13) Have you ever been told that you have, or have you had an X-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>
14) Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>
15) Has a doctor told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>
16) Do you cough, wheeze or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
17) Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>
18) Have you ever used an inhaler or taken asthma medication?	<input type="checkbox"/>	<input type="checkbox"/>
19) Were you born without, are you missing, or do you have a nonfunctioning kidney, eye, testicle or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
20) Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
21) Do you have any rashes, pressure sores or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
22) Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
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")?	<input type="checkbox"/>	<input type="checkbox"/>
24) Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
25) Have you ever had numbness, tingling or weakness in your arms or legs after being hit, falling, stingers or burners?	<input type="checkbox"/>	<input type="checkbox"/>
26) While exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>
27) Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
28) Have you ever been tested for sickle cell trait?	<input type="checkbox"/>	<input type="checkbox"/>
29) Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
30) Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
31) Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
32) Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
33) Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
34) Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
35) Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
36) Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>

**Females Only**

**Explain "Yes" Answers Here**

	Y	N
37) Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
38) How old were you when you had your first menstrual period?	_____	
39) How many periods have you had in the last year?	_____	





## 2021-22 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?	<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"/>

### Explain "Yes" Answers Here

### COVID-19...

	Y	N
1) Has your child been diagnosed with COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
1a) If yes, is your child still having symptoms from their COVID-19 infection?	<input type="checkbox"/>	<input type="checkbox"/>
2) Was your child hospitalized as a result for complications of COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
3) Has your child been diagnosed with Multi-Inflammatory Syndrome in Children (MIS-C)?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
5) Has your child returned back to full participation in sports?	<input type="checkbox"/>	<input type="checkbox"/>
6) Has your child had direct or known exposure to someone diagnosed with COVID-19 in the past 3 months?	<input type="checkbox"/>	<input type="checkbox"/>
6a) Was your child tested for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
7) Did your child receive the COVID-19 vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
7a) What was the manufacturer of the vaccine? _____		
7b) Date of vaccination(s) _____		

### Explain "Yes" Answers Here



**Family History Questions: Please Tell Me About Any Of The Following In Your Family...**

		<b>Y</b>	<b>N</b>		<b>Y</b>	<b>N</b>
1)	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"/>		<input type="checkbox"/>	<input type="checkbox"/>
2)	Are there any family members who died suddenly of "heart problems" before age 50?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
3)	Are there any family members who have unexplained fainting or seizures?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
4)	Are there any relatives with certain conditions, such as:				<b>Y</b>	<b>N</b>
	<b>Y</b>		<b>N</b>			
	Enlarged Heart	<input type="checkbox"/>	<input type="checkbox"/>	Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT)	<input type="checkbox"/>	<input type="checkbox"/>
	Hypertrophic Cardiomyopathy (HCM)	<input type="checkbox"/>	<input type="checkbox"/>	Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)	<input type="checkbox"/>	<input type="checkbox"/>
	Dilated Cardiomyopathy (DCM)	<input type="checkbox"/>	<input type="checkbox"/>	Marfan Syndrome (Aortic Rupture)	<input type="checkbox"/>	<input type="checkbox"/>
	Heart Rhythm Problems	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack, Age 50 or Younger	<input type="checkbox"/>	<input type="checkbox"/>
	Long QT Syndrome (LQTS)	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker or Implanted Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
	Short QT Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Deaf at Birth	<input type="checkbox"/>	<input type="checkbox"/>
	Brugada Syndrome	<input type="checkbox"/>	<input type="checkbox"/>		<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 Student-Athlete                      Signature of Parent/Guardian                      Date

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



## 2021-22 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/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: \_\_\_\_\_  
 Recommendations: \_\_\_\_\_

Name of Physician (Print/Type): \_\_\_\_\_ Exam Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Signature of Physician: \_\_\_\_\_, MD/DO/ND/NMD/NP/PA-C/CCSP

# AIA

ARIZONA  
INTERSCHOLASTIC  
ASSOCIATION

OUR STUDENTS, OUR TEAMS . . . OUR FUTURE.

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