NOLI INDIAN SCHOOL

SOBOBA BAND OF LUISEÑO INDIANS

CLEARANCE PACKET

All items in this packet must be completed and turned into the athletic office before an athlete will be cleared for participation in any sport at Noli Indian School.

PARENT AUTHORIZATION

The student named below has permission (and I am the legal guardian) to participate in athletics at Noli Indian School and to be transported and supervised by authorized persons throughout the school year. Stated in California Education Code Section 35330. I understand that I hold the Noli Indian School System; its officers, agents and employees harmless from any liability or claims, which may arise out of or in connection with my child's participation in athletic events.

_____ _____

Signature of Parent/Legal Guardian Date

PERSONAL INFORMATION

Students Name: _____ Home Phone #: _____

Grade Level: _____ Age: _____ Date of Birth: _____

Home Address: _____

Mailing Address: _____

Mother/Guardian Name & Work Number: _____

Father/Guardian Name & Work Number: _____

PARENT PERMISSION AND EMERGENCY AUTHORIZATION

Please list the name and phone number(s) of the parent or guardian to be notified in an emergency situation.

Parent/Guardian: _____ Home Phone #: _____

Business #: _____ Cell #: _____ _____

Family Physician: _____ Phone #: _____

I do hereby authorize and consent to any x-ray, anesthetic, medical or surgical diagnosis and treatment and emergency hospital care which is deemed advisably by and is rendered under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medicine Practice Act and on the staff of any acute general hospital holding a current license to operate a hospital from the State of California Department of Public Health. It is understood that effort shall be made to contact the above named individual prior to rendering treatment to the patient, but that any of the above.

Treatment will not be withheld if the above named individual cannot be reached. The legal guardian assumes the financial burden for any such procedure. ***Noli Indian School***, its employees or agents. or volunteers will not be responsible for such cost

This authorization is given pursuant to the provision of section 25.8 of the Civil code of California

List any restriction(s): _____

_____ _____

Signature of Parent/Legal Guardian Date

I have read and I understand the athletic Code of Conduct for Noli Indian School. I accept the responsibilities of monitoring the actions of the student athlete whose signature appears above and I will do all I can to ensure that he/she complies with each item of the Athletic Code of Conduct as presently stated or subsequently amended.

_____ _____

Signature of Parent/Legal Guardian Date

Below Check Sport of Choice:

☐ Football	☐ Boys Basketball	☐ Softball	☐ Flag Football	☐ Girls Basketball
☐ Baseball	☐ Volleyball	☐ Track	☐ Cross Country	☐ Golf

NOLI INDIAN SCHOOL

SOBOBA BAND OF LUISEÑO INDIANS

CO-CIRRUCULAR ACTIVITY CERTIFICATE FOR SCHOOL YEAR 20___ / 20___

(Insurance, Indemnification, Medical Authorization)

Pupil's Last Name First Name Middle Initial

School Attended Last Year: _____ City: _____

CHECK SPORTS YOU WILL BE PARTICIPATIONG IN:

☐ Baseball	☐ V. Basketball (Boys)	☐ V. Basketball (Girls)
☐ V. Football	☐ V. Softball	☐ V. Volleyball
☐ Cross Country	☐ Track	☐ Golf
☐ M.S. Basketball (Boys)	☐ M.S. Basketball (Girls)	☐ Flag Football
☐ M.S. Volleyball (Girls)	☐ M.S. Volleyball (Boys)	☐ M.S. Softball

The form must be on file with the school of attendance for verification of eligibility prior to participation in any co-curricular activity.

Note: The California Education Code requires that every student have $1,500 accidental medical insurance in order to participate in athletics or any other extra-curricular activity. (Ed. Code 32220-24)

SECTION I: (IF YOU HAVE YOUR OWN INSURANCE COVERAGE, PLEASE COMPLETE THIS SECTION) My medical coverage is for at least $l,500 and is issued by:

_____ _____

Name of Insurance Policy Policy Number

I further assure that the insurance policy or policies I hereby verify will remain current and in force during the time the above named student performs any function within the scope of Education Code Section 32220-24 and 35330-31 during the current school year of 20___ / _____.

_____ _____

Signature of Parent/Legal Guardian Date

INDEMNIFICATION

1 agree to indemnify and hold the Soboba Band of Luiseño Indians harmless against responsibility for insurance coverage required under the Education Code Sections 32220-24, 35330-31. By signing this statement. I agree to accept responsibility for all medical costs incurred by the above named pupil while participating in any school co-curricular program.

Your attention is directed to the fact that many insurance policies exclude tackle football. Please check your policy carefully or consult your carrier.

_____ _____

Signature of Parent/Legal Guardian Date

NOLI INDIAN SCHOOL

SOBOBA BAND OF LUISEÑO INDIANS

SECTION II

MEDICAL AUTHORIZATION

TO WHOM IT MAY CONCERN:

I, the undersigned, being the legal guardian of _____ do hereby grant to any hospital, emergency center, doctor, nurse, and or paramedic authorization to grant treatment to my child when accompanied by or escorted to the treating facility by a teacher, coach, teacher's aid, principal or any school designee.

Further, should the attending physician determine after examination that life saving surgery or other life-saving procedure may be necessary; permission is hereby extended to the above parties to grant same.

By my action of granting said permission, I agree to hold harmless school personnel, school designee, the Soboba Band of Luiseño Indians, and Noli Indian school.

I declare under penalty of perjury that the above is true and correct.

_____ _____

Signature of Parent/Legal Guardian Date

Home #: _____ Business #: _____ Cell #: _____

Emergency Contact Person: _____ Phone #: _____

Alternate Emergency Contact: _____ Phone #: _____

RESIDENCY

Athlete's Name: _____ Parent/Guardian Name: _____

Address: _____

City: _____ Zip: _____ Phone #: _____

I HEREBY CERTIFY THAT THE ABOVE NAMED STUDENT RESIDES AT THE ABOVE ADDRESS.

_____ _____

Signature of Parent/Legal Guardian Date

TRANSPORTATION

I hereby give consent for the above named student to compete in sports and be transported with a representative of the school on any trips.

_____ _____

Signature of Parent/Legal Guardian Date

I, _____ (Student's Name), understand that playing sports for Noli Indian School is a privilege. I agree to play by the rules and code of ethics set by CIP, Noli Indian School, and the Warrior League. I understand that it is my responsibility to turn in my uniform at the end of the season. If my uniform is not returned, I will have to pay for it or I will be forfeited the opportunity to participate in any other sports/activities offered at Noli.

_____ _____

Signature of Parent/Legal Guardian Date

_____ _____

Signature of Student Date

10932 Pine Street
Los Alamitos, California 90720

Code of Ethics – Athletes

DO NOT SEND TO CIF SOUTHERN SECTION
A copy of this form must be kept on file in the athletic director's office at the local high school.

Athletics is an integral part of the school's total educational program. All school activities, curricular and extra-curricular, in the classroom and on the playing field, must be congruent with the school's stated goals and objectives established for the intellectual, physical, social and moral development of its students. It is within this context that the following Code of Ethics is presented.

As an athlete, I understand that it is my responsibility to:

1. Place academic achievement as the highest priority.
2. Show respect for teammates, opponents, officials and coaches.
3. Respect the integrity and judgment of game officials.
4. Exhibit fair play, sportsmanship and proper conduct on and off the playing field.
5. Maintain a high level of safety awareness.
6. Refrain from the use of profanity, vulgarity and other offensive language and gestures.
7. Adhere to the established rules and standards of the game to be played.
8. Respect all equipment and use it safely and appropriately.
9. Refrain from the use of alcohol, tobacco, illegal and non-prescriptive drugs, anabolic steroids or any substance to increase physical development or performance that is not approved by the United States Food and Drug Administration, Surgeon General of the United States or American Medical Association.
10. Know and follow all state, section and school athletic rules and regulations as they pertain to eligibility and sports participation.
11. Win with character, lose with dignity.

As a condition of membership in the CIF, all schools shall adopt policies prohibiting the use and abuse of androgenic/anabolic steroids. All member schools shall have participating students and their parents, legal guardian/caregiver agree that the athlete will not use steroids without the written prescription of a fully licensed physician (as recognized by the AMA) to treat a medical condition (Article 503.I).

By signing below, both the participating student athlete and the parents, legal guardian/caregiver hereby agree that the student shall not use androgenic/anabolic steroids without the written prescription of a fully licensed physician (as recognized by the AMA) to treat a medical condition. We recognize that under CIF Bylaw 202, there could be penalties for false or fraudulent information. We also understand that the Noli Indian School (school/school district name) policy regarding the use of illegal drugs will be enforced for any violations of these rules.

Printed Name of Student Athlete

Signature of Student Athlete Date

Signature of Parent/Caregiver Date

Revised 6/17

NOLI INDIAN SCHOOL

SOBOBA BAND OF LUISEÑO INDIANS

PREPARTICIPATION PHYSICAL EVALUATION

(To be completed by parent/guardian)

HISTORY

Name: _____ Sex: _____ Age: _____ DOB: _____

Grade: _____ School: _____ Sport(s): _____

Address: _____ Phone #: _____

Personal Physician: _____ Phone #: _____

In case of an emergency contact: Name _____

Phone #: _____ Business #: _____ Cell #: _____

Explain "Yes" answers below. Circle questions you don't know the answer to.

		Y	N
1.	Have you had a medical illness or injury since your last check-up or sport physical?		
2.	Have you ever had surgery?		
3.	Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using inhalers?		
4.	Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?		
5.	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects?		
6.	Have you ever had a rash or hives develop during or after exercise?		
7.	Have you passed out during or after exercise?		
8.	Have you ever been dizzy during or after exercise?		
9.	Have you ever had chest pains during and after exercise?		
10.	Do you get tired more quickly than your friends do during exercise?		
11.	Have you ever had racing of your heart or skipped heartbeats?		
12.	Have you ever had high blood pressure or high cholesterol?		
13.	Have you ever been told you have a heart murmur?		
14.	Have any family member or relative died of heart problems or sudden death before age 50?		
15.	Have you had severe viral infection (for example myocarditis or mononucleosis) within the last month?		
16.	Has a physician ever denied or restricted your participation in sports for any heart problems?		
17.	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?		
18.	Have you ever had a head injury or concussion?		
19.	Have you ever been knocked out, become unconscious or lost your memory?		
20.	Have you ever had a seizure?		
21.	Do you have frequent or severe headaches?		
22.	Have you ever had numbness or tingling in your arms, hands, legs or feet?		
23.	Have you ever had a stinger, burner, pinched nerve?		

		Y	N
24.	Have you become ill from exercising in the heat?		
25.	Do you cough, wheeze, or have trouble breathing during or after activity?		
26.	Do you have asthma?		
27.	Do you have seasonal allergies that require medical treatment?		
28.	Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthopedics, retainer on your teeth, hearing aid?		
29.	Have you ever had problems with your eyes?		
30.	Do you wear glasses, contacts, or protective eye wear?		
31.	Have you ever had a sprain strain or swelling after injury?		
32.	Have you broken or fracture any bones or dislocated any joints?		

33. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?

If yes, check appropriate box and explain below:

☐ Head	☐ Upper arm	☐ Finger	☐ Ankle
☐ Neck	☐ Elbow	☐ Hip	☐ Foot
☐ Back	☐ Forearm	☐ Thigh	
☐ Chest	☐ Wrist	☐ Knee	
☐ Shoulder	☐ Hand	☐ Shin/Calf	

34.	Do you want to weight more or less than you do now?		
35.	Do you lose weight regularly to meet weight requirements for your sport?		
36.	Do you feel stressed out?		

37. Record the dates of your most recent immunizations (shots) for:

Td: _____ Measles: _____

Hep B: _____ Chickenpox: _____

38. **FEMALES ONLY:**

When was your first menstrual period? _____

When was your most recent menstrual period? _____

How much time do you usually have from the start of one period to the start of another? _____

What was the longest time between periods in the last year? _____

Explain "Yes" answers here: _____

NOLI INDIAN SCHOOL

SOBOBA BAND OF LUISEÑO INDIANS

PREPARTICIPATION PHYSICAL EVALUATION

(To be completed by a medical provider)

PHYSICAL EXAMINATION

Name: _____ DOB: _____ Date: _____

Weight: _____ Height: _____ Temp: _____ BP: _____ Pulse: _____ Resp: _____

Vision: R 20/___ L 20/___ Both 20/___ Corrected: ☐ Yes ☐ No Pupils: ☐ Equal ☐ Unequal

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Pulse		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		

MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Shoulder		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

CLEARANCE

☐ Cleared as of this date, I see no reason to exclude from sports.

☐ Cleared after completing evaluation/rehabilitation for: _____

_____

_____

☐ Not Cleared for: _____

Recommendations: _____

_____

_____

Name of Physician (Please Print): _____

Address: _____ Phone #: _____

Signature of Physician: _____ MD/DO/PA-C/NP Date: _____

The information above must be filled in and signed by either a physician, a physician assistant licensed by the California Board of Physician Assistant Examiners, or a Register Nurse recognized as a Nurse Practitioner by the California Board of Nurse Examination. Form signed by any other health care practitioner will not be accepted.

NOLI INDIAN SCHOOL

SOBOBA BAND OF LUISEÑO INDIANS

AUTHORIZATION FOR PRESCRIBED AND OVER THE COUNTER MEDICATION ADMINISTRATION AT SCHOOLS WITHIN THE COUNTY OF RIVERSIDE

Name of Student	Date of Birth	Grade	School

Education code 49423 authorizes that any pupil who is required to take, during the regular school day, medication prescribed for him/her by a physician, may be assisted by the school nurse or other designed personnel if the school district receives (1) written statement from such physician detailing the method, amount, and time schedules by which such medication is to be taken and (2) a written statement from the parent/guardian of the pupil indicating the desire that the school district assist the pupil in the matter set forth in the physician's statement.

I request medication prescribed be administered to my student and agree to hold Noli Indian School, its officers and employees harmless from all liability or claims which might arise out of these arrangements. I give my permission to contact the physician for consultation as needed.

_____ _____

Signature of Parent/Legal Guardian Date

_____ _____

Home Phone Work Phone

PHYSICIAN AUTHORIZATION

ONE MEDICATION PER FORM

Name of Medicine(s)	Health Condition for which medicine RX
Time(s) to be taken	Dosage
Method of administration	Precaution-Possible untoward reactions
Date to be discontinued	Physician's Telephone Number
Name of Physician (Please Print)	Physician's Fax Number
Physician's Signature	Date

Please return this form to the school health office, signed by the physician and the parent or guardian.

THIS FORM MUST BE RENEWED AT THE BEGINNING OF EACH SCHOOL YEAR OR WHENEVER THERE IS A CHANGE IN MEDICATION OR INSTRUCTIONS. NO MEDICATION WILL BE ADMINISTERED WITHOUT THESE REQUIRED SIGNATURES.

PLEASE SEE RESPONSIBLITIES ON REVERSE SIDE.

NOLI INDIAN SCHOOL
SOBOBA BAND OF LUISEÑO INDIANS

VARSITY FOOTBALL
PARENT/GUARDIAN CONSENT FORM

To be filled out for 14 Year Olds Only

As the parent or legal guardian of _____

Student's Name

I permit him to participate in football at the varsity level at Noli Indian School.

_____ _____

Signature of Parent/Legal Guardian Date

NOLI INDIAN SCHOOL
SOBOBA BAND OF LUISEÑO INDIANS

VARSITY FOOTBALL
MEDICAL CONSENT FORM
To be filled out for 14 Year Olds Only

Student Name: _____

As a licensed medical practitioner, I certify that _____ is able
Student's Name
to participate in football at the varsity level.

_____ MD/PA-C/NP _____
Signature Date

Office Stamp

Sports Physical Form

(This section refers to the patient ONLY)
126 Avocado Ave, Suite 102, Perris, CA 92571
12800 Heacock St, Suite A-4, Moreno Valley, CA 92533
T: 951.490.4910 F: 951.490.4920

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Driver License # _____ School Name: _____ DOB: _____

Sex: ☐ Male ☐ Female

Contact Numbers (please check preferred #)

☐ Home: _____

☐ Cell: _____

☐ Work: _____

Parent or Guardian are consenting Rapid Care enterprises Inc. to conduct a sports physical on the child's name listed above while they are not present and coming from the child's school. All information listed on this form is current and accurate. Please sign and date below

Parent or Guardian signature Date:

_____

It is our general policy to follow-up on your care by contacting you within 48 hours of your visit. If you do not wish to be contacted. Please check the box: ☐

Primary Care Physician's (PCP) Name: _____ City/State: _____

Preferred Pharmacy: _____ City/State: _____

EMERGENCY CONTACT

Last Name: _____ First Name: _____ Phone Number: _____

Relationship to the Patient: ☐ Parent ☐ Spouse ☐ Other _____

RESPONSIBLE PARTY

Relationship to the Patient: ☐ Parent ☐ Spouse ☐ Other (skip to next section)

Last Name: _____ First Name: _____ MI: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

INSURANCE INFORMATION

(This section refers to the Insurance Subscriber)

Last Name: _____ First Name: _____ MI: _____ SSN: _____

Relationship to Patient: ☐ Self (skip to next section) ☐ Parent ☐ Spouse ☐ Other (skip to next section) _____

Insurance Carrier: _____ Insurance Carrier: ID #_____

SIGNATURE

I certify that the information provided is correct to the best of my knowledge. I will not hold **RAPID CARE ENTERPRISES INC**., its health providers or its employees responsible for any errors or omissions that I may have made in completing the information on this form. I hereby voluntarily consent to treatment for me or my dependent at **RAPID CARE ENTERPRISES INC**., and authorize such treatments, examinations by its providers. Arbitration Clause: The Patient and Rapid Care Enterprises Inc. agree that any and all disputes that either party may have with other party, which arise out of the Agreement shall be resolved through final and binding arbitration in Riverside County, California in accordance with the rules and regulations of the American Arbitration Association then in effect. Both the parties understand and agree that the arbitration shall be instead of any civil litigation and that the arbitrator's decision shall be final and binding to the fullest extent permitted by law and enforceable by any court having jurisdiction therefore Mediation between both parties will be mandatory before filing an arbitration claim.

Print Name: _____ Relationship to Patient _____

Signature: _____ Date _____