

## ***STUDENT TRAVEL AGREEMENT***

**I SHALL:**

- ◇ obey the student code of conduct in addition to any campus rules of discipline.
- ◇ not possess or use tobacco, illegal drugs or alcohol.
- ◇ remain at all times with sponsor/coach or assigned chaperone.
- ◇ not change buses without permission of the sponsor/coach.
- ◇ secure transportation home upon my return.
- ◇ not use swimming pools or water parks or be involved in any type of recreational water activity unless prior approval has been granted by the principal.

**IF TRIP IS OVERNIGHT, I SHALL ALSO:**

- ◇ not leave the lodging area unless accompanied by the sponsor/coach or assigned chaperone.
- ◇ keep 11:00 p.m. curfew or as set by the sponsor/coach.
- ◇ be allowed to socialize in rooms provided the following guidelines are observed and permission is granted by sponsor/coach.
  - Doors will remain open.
  - Noise level will remain low so that other guests are not disturbed.
  - Students will return to their designated rooms at curfew.
  - Students will **not** have guests of the opposite sex in their rooms at any time.

Signing below indicates reading, understanding and agreeing to follow the above-mentioned rules and accepting the consequences for violations.

\_\_\_\_\_  
Student Name (please print)

**X** \_\_\_\_\_  
Student Signature

**X** \_\_\_\_\_  
Date

I have discussed this Student Travel Agreement with my students.

\_\_\_\_\_  
Sponsor/Coach Signature

\_\_\_\_\_  
Date

# LAWTON PUBLIC SCHOOLS

## *PERMISSION TO TRAVEL*

Our school organization will be traveling to and from events during the \_\_\_\_\_ school year. Care will be taken to ensure your child's safety. Details are as follows:

\_\_\_\_\_ School

\_\_\_\_\_ Group

\_\_\_\_\_ Date(s)

\_\_\_\_\_ Purpose

\_\_\_\_\_ Sponsor/coach

\_\_\_\_\_ has my permission to travel as described above.

**X**

\_\_\_\_\_ Signature of parent or legal guardian

**X**

\_\_\_\_\_ Date

## *PERMISSION FOR MEDICAL TREATMENT*

As parent or legal guardian of \_\_\_\_\_, I hereby give permission for Lawton Public Schools officials to provide and/or authorize medical treatment for my child or to take my child for treatment at the best available hospital or doctor's office in case the injury warrants. I further give permission for the hospital officials or the doctor in charge to take any action necessary to provide the best treatment for my child.

### PLEASE PRINT

\_\_\_\_\_ Parent or legal guardian

\_\_\_\_\_ Home Phone

\_\_\_\_\_ Work Phone

\_\_\_\_\_ Name of emergency contact

\_\_\_\_\_ Emergency Phone

\_\_\_\_\_ Family Physician

\_\_\_\_\_ Physician's Phone

\_\_\_\_\_ List any medication to which your child is allergic:

\_\_\_\_\_ List any medication your child is currently taking:

\_\_\_\_\_ List any other medical information pertinent to medical personnel

**X**

\_\_\_\_\_ Signature of parent or legal guardian

**X**

\_\_\_\_\_ Date

# Preparticipation Physical Examination

**HISTORY**

**DATE OF EXAM** \_\_\_\_\_

Name _____	Sex _____	Age _____	Date of Birth _____
Grade _____	School _____	Sport(s) _____	
Address _____		Phone _____	
Personal Physician _____			
In case of emergency, contact: Name _____ Relationship _____ Phone (H) _____ (W) _____			

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

- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| 1. Have you had a medical illness or injury since your last check up or sports physical? ----- <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have an ongoing or chronic illness? ----- <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized overnight? ----- <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had surgery? ----- <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler? <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? ----- <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? ----- <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a rash or hives develop during or after exercise? ----- <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out during or after exercise? ----- <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been dizzy during or after exercise? ----- <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had chest pain during or after exercise? ----- <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you get tired more quickly than your friends do during exercise? ----- <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had racing of your heart or skipped heartbeats? ----- <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had high blood pressure or high cholesterol? ----- <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been told you have a heart murmur? ----- <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| Has any family member or relative died of heart problems or of sudden death before age 50? ----- <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? ----- <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| Has a physician ever denied or restricted your participation in sports for any heart problems? ----- <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? ----- <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had a head injury or concussion? ----- <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been knocked out, become unconscious, or lost your memory? ----- <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a seizure? ----- <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have frequent or severe headaches? ----- <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had numbness or tingling in your arms, hands, legs, or feet? ----- <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a stinger, burner, or pinched nerve? ----- <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever become ill from exercising in the heat? ----- <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you cough, wheeze, or have trouble breathing during or after activity? ----- <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have asthma? ----- <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have seasonal allergies that require medical treatment? ----- <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. 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 orthotics, retainer on your teeth, hearing aid)? ----- <input type="checkbox"/>                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you had any problems with your eyes or vision? ----- <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you wear glasses, contacts, or protective eyewear? ----- <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever had a sprain, or swelling after injury? ----- <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you broken or fractured any bones or dislocated any joints? ----- <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? <i>If yes, check appropriate box and explain below.</i>  |                          |                          |
| <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Back <input type="checkbox"/> Chest <input type="checkbox"/> Shoulder <input type="checkbox"/> Upper arm <input type="checkbox"/> Elbow <input type="checkbox"/> Forearm                          |                          |                          |
| <input type="checkbox"/> Wrist <input type="checkbox"/> Hand <input type="checkbox"/> Finger <input type="checkbox"/> Hip <input type="checkbox"/> Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Skin/calf <input type="checkbox"/> Ankle <input type="checkbox"/> Foot |                          |                          |
| 13. Do you want to weigh more or less than you do now? ----- <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you feel stressed out? ----- <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Record the dates of your most recent immunizations (shots) for:  |                          |                          |
| Tetanus _____ Measles _____ Hepatitis B _____ Chickenpox _____   |                          |                          |

**FEMALES ONLY**

16. 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? \_\_\_\_\_
- How many periods have you had in the last year? ----- \_\_\_\_\_
- What was the longest time between periods in the last year? ----- \_\_\_\_\_

**Explain "Yes" answers here:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

<b>I hereby state, that, to the best of my knowledge, my answers to the above questions are complete and correct.</b>		
Signature of athlete _____	Signature of parent/guardian _____	Date _____

# Lawton Public Schools

## Preparticipation Physical Examination

### PHYSICAL EXAMINATION

Name _____		Date of Birth _____	
Height _____	Weight _____	% Body fat (optional) _____	Pulse _____ BP ____/____ (____/____, ____/____)
Vision R 20/_____	L 20/_____	Corrected: Y N	Pupils: Equal _____ Unequal _____

	NORMAL	ABNORMAL FINDINGS	INITIAL
<b>MEDICAL</b>			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			

### CLEARANCE

Cleared

Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_

Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_

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

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

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

Signature of physician \_\_\_\_\_, MD or DO

### Lawton Public Schools Athletics General Information and Waiver Form

Athletic injuries will occur. The Lawton Public School District employs a team physician and a certified athletic trainer to work with coaches in providing prevention programs and proper treatment of injuries. The coaches working in our program are well-qualified, professional people. Fundamentals related to each sport will continually and repeatedly be emphasized on and off the field.

Safe equipment and supplies are provided for each athlete. Parents should instruct their son/daughter that he/she is the person who should have the most concern about the safety and proper maintenance of his/her equipment. Players should assume the responsibility for periodic checks and replacement of damaged equipment.

#### Insurance Information

The Oklahoma Secondary School Activities Association provides catastrophic insurance for students in grades 9-12 provided students are participating in interscholastic activities authorized and approved by the Board of Directors. **This insurance provides for catastrophic injuries only. All other injuries necessitating medical care will be the responsibility of the parents, guardian or custody parent.**

#### Waiver and Permission to Administer Non-Prescription Medication

I, \_\_\_\_\_, parent or guardian of \_\_\_\_\_, hereby waive, on behalf of myself and said minor, any claim I or said minor may have against the Lawton Public Schools arising from any athletic injuries sustained by said minor during the school year. I do hereby assume full liability and responsibility for any expenses incurred in connection with said injuries. This is intended to fully release the Lawton Public School District from any liability whatsoever arising from any such injuries. In the event any claim is ever made against the Lawton Public Schools by said minor or any other person on behalf of said minor, I agree to fully indemnify and hold the Lawton Public School District harmless from any such claim, including all expenses incurred in defending that claim.

I also hereby authorize the school nurse, a school administrator, or a designated school employee to administer nonprescription medication in the form of

\_\_\_\_\_ to above said minor.  
(type of medication)

  X    
Parent or Guardian's Signature

  X    
Date

\_\_\_\_\_  
Student's Signature

\_\_\_\_\_  
Date