

# Bloomfield Athletics

## Checklist for forms:

- \_\_\_\_\_ Health Questionnaire
- \_\_\_\_\_ Insurance OR Insurance Waiver
- \_\_\_\_\_ Parental Consent Form
- \_\_\_\_\_ Emergency Card
- \_\_\_\_\_ Physical
- \_\_\_\_\_ Sportsmanship Agreement
- \_\_\_\_\_ Drug and Alcohol Testing
- \_\_\_\_\_ Signature Sheet

## Insurance Waiver

I \_\_\_\_\_ (Parent/Guardian) have insurance provided by  
\_\_\_\_\_ (Insurance Co.) which adequately covers \_\_\_\_\_'s  
participation in all NSAA sanctioned activities for the school year \_\_\_\_\_.

\_\_\_\_\_  
(Parent/Guardian)

\_\_\_\_\_  
(Student)

# Bloomfield Athletics

## Checklist for Signatures:

Both student and Parent/Guardian must sign below confirming that they have read/agreed and signed these forms in this packet.

Student

Parent/Guardian

\_\_\_\_\_

\_\_\_\_\_

NSAA Consent  
Form

\_\_\_\_\_

\_\_\_\_\_

Sportsmanship  
Agreement

\_\_\_\_\_

\_\_\_\_\_

Drug/Alcohol  
Policy

Date \_\_\_\_\_, 20\_\_\_\_

To be completed for students participating in any NSAA activities.

Student and Parent Consent Form



School Year: 20 \_\_\_\_ -20 \_\_\_\_  
 Member School: \_\_\_\_\_  
 Name of Student: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

The undersigned(s) are the Student and the parent(s), guardian(s), or person(s) in charge of the above-named Student and are collectively referred to as "Parent".

The Parent and Student hereby:

- (1) Understand and agree that participation in NSAA sponsored activities is voluntary on the part of the Student and is a privilege;
- (2) Understand and agree that (a) by this Consent Form the NSAA has provided to the Parent and Student of the existence of potential dangers associated with athletic participation; (b) participation in any athletic activity may involve injury or illness of some type; (c) the severity of such injury can range from minor cuts, bruises, sprains, and muscle strains to more serious injuries to the body's bones, joints, ligaments, tendons, or muscles, to catastrophic injuries to the head, neck and spinal cord, and on rare occasions, injuries so severe as to result in total disability, paralysis and death; (d) the severity of an illness, including contagious diseases such as the COVID 19 virus, and bacterial infections may be so severe as to result in disability and death; and, (e) even the best coaching, the use of the best protective equipment and strict observance of rules, injuries are still a possibility;
- (3) Consent and agree to participation of the Student in NSAA activities subject to all NSAA by-laws and rules interpretations for participation in NSAA sponsored activities, and the activities rules of the NSAA member school for which the Student is participating; and,
- (4) Consent and agree to (a) the disclosure by the Member School at which the Student is enrolled to the NSAA, and subsequent disclosure by the NSAA, of information regarding the Student, including the student's name, address, telephone listing, electronic mail address, photograph, date of and place of birth, major fields of study, dates of attendance, grade level, enrollment status (e.g., full-time or part-time), participation in officially recognized activities and sports, weight and height of as a member of athletic teams, degrees, honors and awards received, statistics regarding performance, records or documentation related to eligibility for NSAA sponsored activities, medical records, and any other information related to the Student's participation in NSAA sponsored activities; and, (b) the Student being photographed, video recorded, audio taped, or recorded by any other means while participating in NSAA activities and contests, consent to and waive any privacy rights with regard to the display of such recordings, and waive any claims of ownership or other rights with regard to such photographs or recordings or to the broadcast, sale or display of such photographs or recordings.
- (5) Consent and agree to authorize licensed sports injury personnel to evaluate and treat any injury or illness that occurs during the student's participation in NSAA activities. This includes all reasonable and necessary preventive care, treatment and rehabilitation for these injuries. This would also include transportation of the student to a medical facility if necessary. Such licensed sports injury personnel are independent providers and are not employed by the NSAA.
- (6) Acknowledge that Parents are obligated to pay for professional medical and/or related services; the NSAA shall not be liable for payment of such services. We give permission to any and all of the Student's health care providers and the NSAA and its employees, staff, agents, and consultants to release and discuss all records and information about the Student including otherwise confidential medical information and records. We understand that this release has been requested and may be used for the purpose of determining eligibility pertaining to activities participation, fitness, injury, injury status, or emergency.

I acknowledge that I have read paragraphs (1) through (6) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participation in athletic activities.

Name of Student [Print Name] \_\_\_\_\_ Student Signature \_\_\_\_\_ Date \_\_\_\_\_

I am/(We are) the Student's [circle appropriate choice] (Parent) (Guardian). (I)/(We) acknowledge that (I)/(We) have read paragraphs (1) through (6) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participation in athletic activities. Having read the warning in paragraph (2) above and understanding the potential risk of injury to my Student, (I)/(we) hereby give (my)/(our) permission for \_\_\_\_\_ [insert student name] to practice and compete for the above named high school in activities approved by the NSAA, except those crossed out below:

Baseball	Basketball	Cross Country	Debate	Football	Golf	Journalism
Music	Play Production	Soccer	Softball	Speech	Swim/Dive	Tennis
Track & Field	Unified Bowling	Unified Track & Field	Volleyball	Wrestling		

Parent(s)/Guardian Printed Name(s)*	Parent/Guardian Signature	Date of Signature

Both Mother and Father must sign, unless parents are divorced, the custodial parent must sign, or if the student is not living with parents, the student's legal guardian.

## HEALTH QUESTIONNAIRE FOR SPORTS CANDIDATES

(To be completed by athlete with parental assistance if necessary)

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_/\_\_\_/\_\_\_

HOME ADDRESS \_\_\_\_\_ STUDENT'S PHONE \_\_\_\_\_

PARENT'S NAME(S) 1. \_\_\_\_\_, 2. \_\_\_\_\_

PARENT'S PHONE 1. \_\_\_\_\_ 2. \_\_\_\_\_

SCHOOL (JR HIGH) (HIGH SCHOOL) GRADE YOUR GOING INTO 7 8 9 10 11 12.

SPORTS YOU WANT TO PLAY (CIRCLE)

BASKETBALL, CROSS COUNTRY, FOOTBALL, GOLF, TRACK, VOLLEYBALL, WRESTLING

1. Have you ever been told not to participate in any sport? YES\_\_\_ NO\_\_\_
2. Have you ever been unconscious or lost memory  
from a blow on your head? YES\_\_\_ NO\_\_\_
3. Have you ever had a fracture or dislocation? YES\_\_\_ NO\_\_\_
4. Have you ever had a bad knee or ankle sprain? YES\_\_\_ NO\_\_\_
5. Have you had other serious injuries? YES\_\_\_ NO\_\_\_
6. Are you injured or ill now? YES\_\_\_ NO\_\_\_
7. Do you have allergies (hay fever, asthma, hives, or to foods or medicines?) YES\_\_\_ NO\_\_\_
8. Have you ever fainted or blacked out during exercise? YES\_\_\_ NO\_\_\_
9. Has any close relative had heart problems before age 40 years? YES\_\_\_ NO\_\_\_
10. Do you take any kind of medicine every day? YES\_\_\_ NO\_\_\_
11. Have you been a patient in a hospital for an operation or any other reason? YES\_\_\_ NO\_\_\_
12. Do you have any worries about your health or other questions you would  
like to discuss with a physician? YES\_\_\_ NO\_\_\_

Please explain any questions answered with "yes" in the space below.

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# PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam \_\_\_\_\_

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

**Medicines and Allergies:** Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

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Do you have any allergies?  Yes  No If yes, please identify specific allergy below.

Medicines  Pollens  Food  Stinging Insects

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

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, 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 <input type="checkbox"/> Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	Yes	No
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

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I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

# ■ PREPARTICIPATION PHYSICAL EVALUATION THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam \_\_\_\_\_

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	<b>Yes</b>	<b>No</b>
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

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Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

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I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

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# PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

## PHYSICIAN REMINDERS

- Consider additional questions on more sensitive issues
  - Do you feel stressed out or under a lot of pressure?
  - Do you ever feel sad, hopeless, depressed, or anxious?
  - Do you feel safe at your home or residence?
  - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
  - During the past 30 days, did you use chewing tobacco, snuff, or dip?
  - Do you drink alcohol or use any other drugs?
  - Have you ever taken anabolic steroids or used any other performance supplement?
  - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
  - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION			
Height	Weight	<input type="checkbox"/> Male <input type="checkbox"/> Female	
BP / ( / )	Pulse	Vision R 20/	L 20/ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS	
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)			
Eyes/ears/nose/throat • Pupils equal • Hearing			
Lymph nodes			
Heart <sup>a</sup> • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)			
Pulses • Simultaneous femoral and radial pulses			
Lungs			
Abdomen			
Genitourinary (males only) <sup>b</sup>			
Skin • HSV, lesions suggestive of MRSA, tinea corporis			
Neurologic <sup>c</sup>			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
Functional • Duck-walk, single leg hop			

<sup>a</sup>Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.  
<sup>b</sup>Consider GU exam if in private setting. Having third party present is recommended.  
<sup>c</sup>Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- Cleared for all sports without restriction
- Cleared for all sports without restriction with recommendations for further evaluation or treatment for \_\_\_\_\_

- Not cleared
- Pending further evaluation
  - For any sports
  - For certain sports \_\_\_\_\_
- Reason \_\_\_\_\_

Recommendations \_\_\_\_\_

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_  
 Signature of physician \_\_\_\_\_, MD or DO

# ■ PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

Name \_\_\_\_\_ Sex  M  F Age \_\_\_\_\_ Date of birth \_\_\_\_\_

Cleared for all sports without restriction  
 Cleared for all sports without restriction with recommendations for further evaluation or treatment for \_\_\_\_\_

Not cleared  
 Pending further evaluation  
 For any sports  
 For certain sports \_\_\_\_\_  
Reason \_\_\_\_\_

Recommendations \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).**

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_  
Signature of physician \_\_\_\_\_, MD or DO

### EMERGENCY INFORMATION

Allergies \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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



# Sportsmanship Agreement

Show class, have pride, and display character.  
If you do, winning takes care of itself.

Coach Paul 'Bear' Bryant

I \_\_\_\_\_ and \_\_\_\_\_  
(Athlete) (Parent/guardian)  
understand that with team participation comes certain responsibility, namely to represent the school and community in a manner which reflects class, dignity and championship behavior. Championship behavior is defined as, but not limited to the following:

1. Respecting all teammates, coaches, opponents, officials and spectators.
2. Using language deemed appropriate by mothers, grandparents, pastors/priests.
3. Accepting officials decisions; in accordance with that is accepting the fact that all disadvantageous decisions by officials may be overcome by my team through determination and hard work and refusal to give up.
4. Representing the school and community not only on athletic fields, but in the stands at games, in the classroom and on road trips
5. Understanding that self-discipline- the decisions made when no one is watching- have lasting impact on my character and change the mediocre in to the great.
6. Working daily to be a better citizen as well as a better athlete.
7. Having PRIDE in "being a Bee"

I accept the terms and condition of team membership in the Bloomfield athletic program. I also understand that failure to abide by these conditions may result in suspension from competition in athletic contests.

\_\_\_\_\_  
Signature of athlete

## **Return to Play Progression (print this form)**

Return to Play protocol following a concussion should follow a stepwise process. Step 1 represents the timeframe until post-concussion symptoms resolve completely (see Concussion Symptom Inventory Form/Sideline Assessment Tool). This phase will vary considerably among individuals, and may be affected by age, prior history of head injury, injury severity, number of symptoms, and possibly gender among other clinical considerations. Step 1 and the complete resolution of symptoms on average occur within 7-10 days, but may extend longer for others. Progression to Step 2 of the Return to Play Progression can not occur until all post-concussion symptoms have resolved, and the student has returned to the classroom without modifications or accommodations being needed.

Progression to the next step and each step thereafter requires the athlete to remain symptom-free (asymptomatic). Generally, a minimum span of 24-48 hours should transpire between steps (after completing Step 2), with each exercise bout being at least 30 minutes or more in duration unless noted otherwise. The athlete should be continually monitored for the return of any symptoms during exercise and afterwards. If at any time an athlete experiences any post-concussion symptoms, they are to stop and rest until symptom-free once again for 24-48 hours before resuming the progression at the level when symptoms returned.

### **1. Rest, No Exertional Activities until Symptom-free (asymptomatic)**

- Physical & Cognitive (mental) Rest
  
- 2. Light, Aerobic Activities
  - Walking, Biking; No weight lifting
  - Review Post-Concussion Symptom Checklist
    - following 10-20 minutes of *light*, exertional activity
  
- 3. Sport/Position/Event Specific Exercises & Drill
  - Individualized, light - moderate conditioning/running drill, agility drills, light weight lifting; throwing, catching, kicking, shooting, passing, mat drills, conducted away from formal practices.
  - Continue to monitor Post-Concussion Symptoms (checklist)
  
- 4. Non-Contact practice
  - Continue to monitor Post-Concussion Symptoms (checklist)
  - Inspect helmet; assure fit & properly functioning systems
  
- 5. Full-Contact practice
  - Continue to monitor Post-Concussion Symptoms (checklist)
  
- 6. Competition
  - Continue to monitor Post-Concussion Symptoms (checklist)

*No athlete under the age of 19 should be allowed to return to play while presenting with any SYMPTOMS of a potential head injury (McCrory, 2008).*

*Everyone involved in playing sports – athletes, parents, and coaches should be relegated to RECOGNIZE signs and symptoms of a concussion head injury, while those responsible for the decision to return to play and managing concussed athletes should be left to appropriate licensed healthcare professionals with formal training and experience in managing sports concussions where doing so falls within their scope of practice and state licensure.*

StudentsDrug and Alcohol Testing1. Need for Random Testing.

The Board of Education is responsible for maintaining discipline, health and safety. The Board recognizes that student substance abuse presents a continuing challenge and a danger to the student population as a whole. The Board is committed to maintaining competitive extracurricular activity programs in a safe, healthy and secure environment. The Board is further committed to being proactive in ensuring that students who participate in extracurricular activities represent the District in a positive manner.

2. Eligibility for Random Testing.

Students who participate in competitive extracurricular activities at the Junior/Senior high school (Grades 7-12) level are eligible for random testing. Competitive extracurricular activities are activities which are sponsored or approved by the Board, but are not offered for credit towards graduation, and which involve competition, comparison, or judging of the individuals or groups with other individuals or groups as part of selection or participation. Competitive extracurricular activities include, but are not limited to, Athletic Programs, Cheerleading, Band, Academic Teams, One-Act, Choir, Quiz Bowl, FFA, FCCLA and Speech Team.

To participate in a competitive extracurricular activity, students must submit a completed Consent to Test Form on or before the first practice or on or before the first event or meeting, whichever is applicable. The form must be signed by the student and the student's parent or guardian.

Failure to submit a completed Consent to Test Form will result in ineligibility for participation in competitive extracurricular activities until the form is submitted.

Students remain eligible for testing from the date the Consent to Test Form is turned in until a Drop Form is completed, or until the student graduates or is otherwise no longer enrolled in the District. A student for whom a Drop Form has been submitted shall be ineligible for participation in competitive extracurricular activities for twelve months from the date the Drop Form is submitted. Students have a fifteen (15) day grace period for reconsideration of a Drop Form.

Students who are not participants in a competitive extracurricular activity may volunteer for participation in the testing program by submitting a completed Consent to Test Form.

## 3.

Testing Procedure.a. Random Testing.

A confidential testing schedule will be created by the Superintendent or designee to ensure that the testing of eligible students is conducted in a manner that is random. To maintain confidentiality and to maintain the integrity of the randomness of this program, the students eligible for testing will be identified by a unique personal identifier that does not make the student known to persons other than the school officials who are directly involved in the testing program.

No less than twenty percent (20%) of the pool of eligible students will be tested each school year. The Superintendent shall have the authority to determine the percentage to test, subject to the minimum 20% level, dependent on the nature and extent of the prevailing problem with drug usage in the school community from time to time. Testing will take place throughout the school year.

b. Collection.

The testing collection process will be conducted in a manner that protects student privacy, will also guard against tampered specimens and ensuring an accurate chain of custody of the specimen. To the extent the testing involves the collection of urine, an adult monitor is to wait outside a closed restroom stall and listen for the normal sounds of urination.

The specific testing procedures and mechanism are to be created by the Superintendent or designee. It is intended that the procedures be modeled on those applicable to the testing of CDL employees, which include the testing of specimens for alcohol and unlawful substances. The tests are to be designed to detect only the use of illegal drugs, including but not limited to amphetamines, marijuana, cocaine, steroids, opiates, and barbituates, not medical conditions or the presence of authorized prescription medications.

4. Confidentiality.

All activities related to the testing policy will be carried out in accordance with the requirements of the Family Educational Rights and Privacy Act (FERPA), the Protection of Pupil Rights Amendment (PPRA), and any other applicable confidentiality laws.

Test results will be shared only with staff who have a legitimate educational interest in having access to the information, on a "need to know" basis. Test results will not be turned over to any law enforcement authority in the absence of a court order, subpoena, or other legal process requiring such.

Test results will be kept in confidential files separate from the students' other records. The test results will be destroyed when no longer needed for individual student situations or for the overall testing program.

5. Consequences for Positive Tests.

Any of the following shall be considered to be a positive test result:

- A confirmed positive alcohol or drug test;
- Refusal to participate in testing when selected, including the submission of a Drop Form upon being requested to be tested; and/or
- Tampering with the specimen collection process.

The following shall result from a positive test result:

- The student's parents or guardians will be contacted and a meeting will be held to discuss the positive test result, with the object of collaborating on a plan to assist the student in avoiding future substance abuse.
- The student's privilege of participating in extracurricular activities will be restricted as follows:
  - For a first positive test, the student is ineligible to participate in any extracurricular activities for twenty (20) school days. The student may continue to participate in extracurricular activities if within ten (10) school days of the meeting with the parents or guardians the student shows proof that the student is receiving substance abuse counseling with a qualified professional and submits to a second drug test within two (2) weeks.
  - For a second and subsequent positive test, the student is ineligible to participate in any extracurricular activity for 1 calendar year. To return to participation, the student must complete substance abuse counseling as and to the extent determined appropriate by a qualified professional, and in any event for no less than four (4) hours, and must submit to five (5) follow up drug tests during the next twelve month period.

The parents or guardians are responsible for the costs of the rehabilitation program, which includes the substance abuse counseling and follow-up testing described above.

Positive results will not lead to the imposition of any academic consequence or disciplinary action, other than the above-described limitations on the privilege to participate in extracurricular activities.

6. Appeal Procedures.

A student or the student's parents or guardians may request a retest of his/her specimen at their own expense at a laboratory approved by the Superintendent or designee and which follows federal Substance Abuse and Mental Health Services Administration (SAMHSA) standards concerning drug testing protocols and procedures. Requests must be made within twenty-four (24) hours of receiving the results of their drug test. The specimen previously submitted will be forwarded to the approved lab in cooperation with the District approved outside agency responsible for confirmatory testing.

Results of the re-test will be provided to the Superintendent or designee by the approved laboratory. During the appeal period the student may not participate in competitive extracurricular activities.

In the event a student or the student's parents or guardians wish to challenge a positive test result on a basis other than the veracity of the test result, an appeal may be made in accordance with the policy on extracurricular activity discipline.

Date of Adoption:

## ACTIVITIES

### Random Drug Testing Consent to Test Form

I understand fully that my performance as a student and the reputation of my school are dependent, in part, on my conduct as an individual. I hereby agree to accept and abide by the standards, rules and regulations set forth by the Board of Education of Bloomfield Community Schools, the administration, and the coaches and sponsors for the activities in which I participate.

I consent to and authorize Bloomfield Community Schools to conduct a drug and alcohol test if my number is drawn from the random pool. I also authorize the release of information concerning the results of such tests to designated District personnel.

I understand that this form remains in effect until the submission of an Activity Drop Form or graduation and/or withdrawal from the District.

<hr/>	<hr/>	<hr/>
Student Name (print)	Student Signature	Date

<hr/>	<hr/>	<hr/>
Parent or Guardian Name (print)	Parent or Guardian Signature	Date

I plan to participate in one or more of the following competitive extracurricular activity(ies): Football, Volleyball, Cross Country, Basketball, Wrestling, Speech, One Act, FCCLA, FFA, Music, Band, Track, Golf, Cheer.

\_\_\_\_\_ I am volunteering to be placed in the testing pool.

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**Activity Drop Form**

I, \_\_\_\_\_ wish to withdraw from \_\_\_\_\_

I will submit this form to the Athletic Director. My name will be withdrawn from the testing pool on the date this is received by the Athletic Director. AD Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Completing this form will pertain to all competitive extracurricular activities. I understand, by withdrawing, I can no longer participate in any competitive extra-curricular activities, and I may not receive recognition as a member of these activities or athletic programs. I may re-enter the testing pool after a period of one (1) calendar year by filling out a new Consent to Test form.

I UNDERSTAND THAT I HAVE 15 DAYS TO RECONSIDER THE DECISION AND RE-ENTER THE POOL.

<hr/>	<hr/>	<hr/>
Student Name (print)	Student Signature	Date

<hr/>	<hr/>	<hr/>
Parent or Guardian Name (print)	Parent or Guardian Signature	Date

**BLOOMFIELD ATHLETICS**  
Emergency Identification Card  
(To be filled out by the athlete and his/her parent/guardian)

Athlete Name: \_\_\_\_\_ Grade: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sport: \_\_\_\_\_

Parent/Guardian Name(s) \_\_\_\_\_

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

Emergency Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Chronic Ailments / Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I, \_\_\_\_\_, parent or guardian of \_\_\_\_\_  
in consideration of my child's opportunity to participate in interscholastic activities, hereby consent to  
emergency medical treatment as may be necessary for the above named child, and hereby waive any  
liability of the school district or its employees arising out of such medical treatment

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