

School Year: \_\_\_\_\_

## INTERSCHOLASTIC **(GREEN)** ATHLETIC PARTICIPATION FORM

Acton-Boxborough Regional Schools  
978-264-4700 Ext. 3420

Student athletes are responsible for having this form completed by a Parent/Guardian and the Health Office **PRIOR** to trying out for any sport. Completed forms should be returned to your coach on the 1<sup>st</sup> day of tryouts.  
**NOTE: Students without a completed form will NOT be allowed to participate.**

Attached to this form, please provide a copy of your most recent physical examination. The form must state date of examination and whether or not the student is physically fit for competitive sports.

### TO BE COMPLETED BY PARENT OR GUARDIAN

(Please Print)

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Parent/Guardian: \_\_\_\_\_  
Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Emergency: \_\_\_\_\_

I give permission for \_\_\_\_\_ to participate in interscholastic sports.

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

Please list pertinent medical information to be shared with the School Nurse, Athletic Trainer and coach. If medical needs change, it is the responsibility of the parent/guardian to notify the school health office and coach.

Allergies (please list) \_\_\_\_\_  
EPI Pen: yes/no      Asthma: Yes / No      Inhaler: Yes / No

Medical Information: \_\_\_\_\_

Present Medications: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

### **STATE LAW REGARDING SPORTS-RELATED HEAD INJURY & CONCUSSIONS**

The Commonwealth of Massachusetts Executive Office of Health and Human Services now requires that all schools subject to the Massachusetts Interscholastic Athletic Association (MIAA) adhere to a new law regarding sports-related head injuries and concussions. The law requires:

1. Athletes and their parents to inform their coaches about prior head injuries at the beginning of the season.
2. If a student athlete becomes unconscious during a game or practice, the law now mandates taking the student out of play or practice, and requires written certification from a licensed medical professional for "return to play."
3. That student athletes and their parents (as well as coaches, athletic directors, school nurses and physicians and others) learn about the consequences of head injuries and concussions through training programs and written materials.

As a result of this new law, parents and students who plan to participate in any athletic program at Acton-Boxborough Regional School District must take a free on-line course to educate themselves about sports-related head injuries and concussions. The state has made available two free on-line courses that contain all the information required by the law. The first is available through the National Federation of High School Coaches. You will need to click the "order here" button and complete a brief information form to register. At the end of

the course, you will receive a completion receipt. The entire course, including registration, can be completed in less than 30 minutes.

- Safety Regulations for school athletic programs:

Sports related head injuries:

Information for parents:

<http://www.nfhslearn.com/electiveDetail.aspx?courseID=15000>

OR

[http://www.cdc.gov/concussion/HeadsUp/online\\_training.html](http://www.cdc.gov/concussion/HeadsUp/online_training.html)

### Head injury History

Concussion History Yes \_\_\_\_\_ No \_\_\_\_\_

Date of injuries \_\_\_\_\_

Signatures confirm that materials/information regarding concussion information was received and understood.

\_\_\_\_\_  
Parent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student

\_\_\_\_\_  
Date

### **TO BE COMPLETED BY HEALTH OFFICE**

*NOTE: School Nurse will review and detach physical and keep on file in the Health Office.*

Health Office: Current Physical Exam: Yes / No \_\_\_\_\_  
Date of Expiration: \_\_\_\_\_  
Activity Restriction: Yes / No \_\_\_\_\_

Signature of Health Office Personnel: \_\_\_\_\_ Date: \_\_\_\_\_

### **This to be filled out by RJ Grey only**

Signature of Counselor: \_\_\_\_\_ Date: \_\_\_\_\_  
(Counselor's signature indicates Academic Eligibility to participate)

ABRHS Grades  
are reviewed by  
Athletic Director