HIGH SCHOOL & JR HIGH SCHOOL IMPORTANT INFORMATION 2021-2022

MELBA MUSTANGS FALL SPORTS

Start Dates

High School Fall Sports start date = August 9th
Junior High Fall Sports start date = August 18th(approx)

Paperwork Requirements

Due before athlete can begin first practice

Physical = 6th, 7th, 9th, and 11th Graders
Interim Questionnaire = 8th, 10th, and 12th Graders
Activity Policy & Emergency Release Waiver = Everyone (Each calendar year)
Concussion Paperwork = Everyone (Each calendar year)
(1 signed document per family-must list children's names on document)

Pay 2 Participate

Due before the first event of the season

High School Sports = $50 per sport
Junior High Fall Sports = $25 per sport

SCAN FOR LINK TO ATHLETIC PAGE.

Local Physical Information

St Luke's Family Practice clinic on Greenhurst would be the closest to your athletes. There are other urgent cares and groups in Kuna as well. Location & Contact Info3165 E. Greenhurst Rd.Nampa, ID 83686
(208) 463-7330Fax: (208) 463-7331

Fall Coaches

HS Football = Juan Colunga jcolunga@melbaschools.org
JH Football = Jason Millus jmillus@melbaschools.org
HS Volleyball = Curtis Johnson cujohnson@nsd131.org
8TH Grade Volleyball = Laurie Johnson
7th Grade Volleyball = Shayla Neibaur shaylaneibaur@gmail.com
HS XC = Conrad Evanow cevanow@melbaschools.org
JH XC = Kelli Leavitt klevitt@melbaschools.org
HS Cheer = Cathy Fong cathyfong@live.com
Athletic Director = Casey Clark cclark@melbaschools.org

Emergency Release Waiver = Everyone (Each calendar year)

MELBA HIGH SCHOOL EMERGENCY MEDICAL RELEASE WAIVER

I hereby certify that my daughter/son (name of player)

is in normal health with no known physical limitations and is capable of participating in Melba athletic programs. I understand that the use of Melba School District facilities is a privilege and that there are inherit risks while participating. STUDENTS DO GET INJURED. I agree that the Melba School District and those people involved in supervision will not be held responsible for any physical harm my child could incur while participating in or traveling to activities. Coaches can use this form in case of emergency to contact parents or physicians.

ADDRESS_____ CITY_____ STATE_____ ZIP_____

HOME PHONE_____ WORK PHONE_____

FAMILY DOCTOR_____ _____ PHONE_____

EMERGENCY PHONE NUMBERS_____ CELL _____

MEDICAL INFORMATION:

HEART CONDITION OR DISEASE	YES	NO
DIABETES	YES	NO
CONVULSION DISORDER	YES	NO
ASTHMA	YES	NO
ALERGIC TO MEDICATION	YES	NO
ALERGIC TO INSECT STINGS	YES	NO

CURRENT MEDICATION_____

DATE OF LAST TETANUS SHOT_____

OTHER IMPORTANT INFORMATION_____

PARENT/GUARDIAN SIGNATURE _____

Date_____

Activity Policy = Everyone (Each calendar year)

Melba Schools Activity Policy
Melba School District Insurance Waiver and Release
Participant's Name_____

Please sign this Exhibit to indicate you have read and understand the Melba Activities Policy (which includes the District Activities Illegal Drug and Alcohol Policy.) This policy will be in force when the undersigned student participant participates at Melba Junior High and High Schools. Our goal is to have the best and safest activities programs possible and for our student participants to become positive contributing members of society. Please return this sheet signed and dated. Please complete the Insurance Waiver and the Drug Testing Consent as well as the Medical Release Waiver. These forms will be kept by the Activities Director. We provide complete Activity Policies to new participants and they are available upon request for others.

Melba School District Insurance Waiver and Release

Please check one blank:

_____ Our personal family insurance covers our child for the coming year.

_____ Our child is not covered by insurance and we waive any and all claims against the District for any injury arising during any District Activity in which our child is participating.

_____ We have purchased insurance through an independent carrier.

Drug Testing Consent Form

We, the undersigned student and parent/guardian, understand that much of the student's performance as a participant in the District Activities and the reputation of my school are dependent on the student's conduct as an individual. The student and parent/guardian therefore authorize the Melba School District to conduct random testing of urine samples that the student will supply. The purpose of which is to test for illegal drug or alcohol use. We also authorize the district to conduct searches of the student if based on a reasonable suspicion that the student has violated the law or the District Activities Policy. We also unconditionally authorize the release of information regarding test results and searches to the authorized personnel of the district to law enforcement if there is a second or third offense as defined by the policy. A copy of that policy is available on request.

By signing this form you are indicating that you understand the athletic policy requires certain conducts, that your child is covered by insurance or you have made other arrangements and that you agree to allow your child to be randomly drug tested during their activities season.

Student Participant Signature_____ Date_____

Parent/Guardian Signature_____ Date_____

Interim Questionnaire = 8th, 10th, and 12th Graders (1page)

INTERIM QUESTIONNAIRE

It is required all students complete a history and physical examination prior to his/her first 9th and 11th grade practice in the interscholastic (9-12) athletic program in the State of Idaho. The exam is at the expense of the student and may not be taken prior to May 1 of the 8th and 10th grade years. This examination is to be done by a licensed physician, physician's assistant or nurse practitioner under optimal conditions. Interim history forms are required during the 10th and 12th grade years and must be submitted to the school administration prior to the first practice.

Name:_____ Date of birth:_____ Sex: M / F

Address:_____ Phone:_____

School: _____ Participation Grade: _____

MEDICAL HISTORY

SINCE LAST PHYSCAL EXAMINATION, HAS THIS STUDENT:

Fill in details of "YES" answers in space below:	Yes	No
1. Had surgery?	☐	☐
2. Been hospitalized?	☐	☐
3. Been under a physician's care	☐	☐
4. Had serious illness?	☐	☐
5. Had an injury requiring a physician's care?	☐	☐
6. Been rendered unconscious?	☐	☐
7. Been diagnosed with a concussion?	☐	☐
8. Started taking any new medications?	☐	☐
9. Developed any new drug allergies?	☐	☐
10. Developed any health problems?	☐	☐

Explain "YES" answers: _____

CONSENT FORM

(Parent or guardian and student permission and approval)

I herby consent to the above named student participating in the interscholastic athletic program at his/her school of attendance. This consent includes travel to and from athletic contests and practice sessions. I further consent to treatment deemed necessary by physicians designated school authorities for any illness or injury resulting from his/her athletic participation. I also consent to release of any information contained in this form to carry out treatment and healthcare operations for the above named student.

PARENT OR GUARDIAN SIGNATURE_____ DATE_____

This application to compete in interscholastic athletics for the above school in entirely voluntary on my part and is made with the understanding that I have not violated any of the Eligibility rules and regulation of the State Association.

SIGNATURE OF STUDENT_____ DATE_____

Note: The original copy of this form MUST be returned to the school

Physical = 6th, 7th, 9th and 11th Graders
(1 of 2pgs)

HEALTH EXAMINATION *and* CONSENT FORM

It is required all students complete a history and physical examination prior to his/her first 9th and 11th grade practice in the interscholastic (9-12) athletic program in the State of Idaho. The exam is at the expense of the student and may not be taken prior to May 1 of the 8th and 10th grade years. This examination is to be done by a licensed physician, physician's assistant or nurse practitioner under optimal conditions. Interim history forms are required during the 10th and 12th grade years and must be submitted to the school administration prior to the first practice.

Name: _____ Sex: M / F Date of birth: _____ Age: _____

Address: _____ Phone: _____

School: _____ Sports: _____ Participation Grade: _____

MEDICAL HISTORY

Fill in details of "YES" answers in space below:	Yes	No
1. Have you ever been hospitalized?	☐	☐
Have you ever had surgery?	☐	☐
2. Are you presently taking any medication or pills?	☐	☐
3. Do you have any allergies (medicine, bees, other insects)?	☐	☐
4. Have you ever passed out during or after exercise?	☐	☐
Have you ever been dizzy during or after exercise?	☐	☐
Have you ever had chest pain during or after exercise?	☐	☐
Do you tire more quickly than your friends during exercise?	☐	☐
Have you ever had high blood pressure?	☐	☐
Have you been told you have a heart murmur?	☐	☐
Have you ever had racing of your heart or skipped heartbeats?	☐	☐
Has anyone in your family died of heart problems or a sudden death before age 50?	☐	☐
5. Do you have any skin problems (itching, rash, acne)?	☐	☐

	Yes	No
6. Have you ever had a head injury?	☐	☐
Have you ever been knocked out or unconscious?	☐	☐
Have you ever been diagnosed with a concussion?	☐	☐
Have you ever had a seizure?	☐	☐
Have you ever had a stinger, burned or pinched nerve?	☐	☐
7. Have you ever had heat or muscle cramps?	☐	☐
Have you ever been dizzy or passed out in the heat?	☐	☐
8. Do you have trouble breathing or do you cough during or after exercise?	☐	☐
9. Do you use special equipment (pads, braces, neck rolls, mouth guard or eye guards, etc.)?	☐	☐
10. Have you ever had problems with your eyes or vision?	☐	☐
Do you wear glasses, contacts or protective eyewear?	☐	☐
11. Have you had any other medical problems (infectious mononucleosis, diabetes, ect.)?	☐	☐

12. Have you had a medical problem or injury since your last evaluation? ☐ Yes ☐ No

13. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any of bones or joints?

☐ head ☐ back ☐ shoulder ☐ forearm ☐ hand ☐ hip ☐ knee ☐ ankle
☐ neck ☐ chest ☐ elbow ☐ wrist ☐ finger ☐ thigh ☐ shin ☐ foot

14. Were you born without a kidney, testicle, or any other organ? ☐ Yes ☐ No

15. When was your first menstrual period? _____

When was your last menstrual period? _____

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

Explain "YES" answers: _____

CONSENT FORM

(Parent or guardian and student permission and approval)

I herby consent to the above named student participating in the interscholastic athletic program at his/her school of attendance. This consent includes travel to and from athletic contests and practice sessions. I further consent to treatment deemed necessary by physicians designated school authorities for any illness or injury resulting from his/her athletic participation. I also consent to release of any information contained in this form to carry out treatment and healthcare operations for the above named student.

If the health care provider's exam will be performed without compensation as part of the school's health examination program for participation in high school activities, I agree to the waiver provisions as set forth in Idaho Code Section 39-7703 and agree that the health care provider shall be immune from liability as specified in said section.

PARENT OR GUARDIAN SIGNATURE _____ DATE: _____

This application to compete in interscholastic athletics for the above school is entirely voluntary on my part and is made with the understanding that I have not violated any of the eligibility rules and regulation of the State Association.

SIGNATURE OF STUDENT _____ DATE: _____

Physical = 6th, 7th, 9th and 11th Graders (2 of 2pgs)

Idaho High School Activities Association

Physical Examination Form

Name: _____ Date of Birth: _____

Height _____ Weight _____ BP _____ / _____ Pulse _____

Vision R 20 / ____ L 20 / ____ Corrected: Y N

	Normal	Abnormal findings
Medical		
Pulses		
Heart		
Lungs		
Skin		
Ears, nose, throat		
Pupils		
Abdomen		
Genitalia (males)		
Musculoskeletal		
Neck		
Shoulder		
Elbow		
Wrist		
Hand		
Back		
Knee		
Ankle		
Foot		
Other		

CLEARANCE / RECOMMENDATIONS

Clearance:

A. Cleared for all sports and other school-sponsored activates.

B. Cleared after completing evaluation/rehabilitation for:

_____

C. NOT cleared to participate in the following IHSAA sponsored sports /activities:

baseball basketball cheer/dance cross country football golf

soccer softball swimming tennis track volleyball wrestling

NOT cleared for other school-sponsored activities *(example: lacrosse)*:

_____

D. Student is NOT permitted to participate in high school athletics.

Reason: _____

Recommendation:

Name of physician:

Address: _____ Phone: _____

Signature of physician/medical provider: _____ Date: _____

(This *Physical Examination Form* MUST be signed by a licensed physician, physician assistant or nurse practitioner)

Melba Sports Medicine

Dear Parents and Incoming Athletes,

It is my pleasure to continue as the Athletic Trainer at Melba High School. As our sports seasons are underway, I wanted to reach out and remind you of the athletic training services available here. This year, I have ten student aides who will work with me to help keep the athletes covered. These are seniors who have completed the necessary courses and training and who have demonstrated the appropriate skills needed to provide first aid care and basic taping services.

As the Certified Athletic Trainer for the district, I provide the following services:

- Daily medical coverage, taping as needed, injury evaluations/management
- Concussion evaluation and management including return to play
- Injury assessments and recommendations for follow up care
- Fast track referral to sports medicine physicians
- First aid treatments and organization/implementation of emergency protocols
- Education and instruction for student athletes, coaches and parents
- Student education in sports medicine career paths

The athletic training room is available after school and during home events for the athletes who need to see the athletic trainer for evaluation and taping, or to receive treatment and perform rehabilitative exercises. If your son or daughter has sustained an injury, please know that I will do whatever I can to help them care for the injury so they can return to play as soon as safely possible. I will evaluate the injury and refer as needed to a physician.

Please inform the coach and/or the Athletic Trainer if your child intends to see a physician. ***ANYTIME AN ATHLETE SEES A PHYSICIAN FOR AN INJURY, A DOCTORS' NOTE MUST BE PROVIDED TO THE ATHLETIC TRAINER PRIOR TO RETURN TO ACTIVITY.*** The note should include diagnosis, restrictions, any rehabilitation requirements, and date the athlete may return to activity. The athlete must still must pass a functional evaluation prior to return to sport. Concussions require a minimum of 7 days before possible return to play.

It is the student-athletes responsibility to report all injuries/illness to the coach and Certified Athletic Trainer as soon as is possible. This includes all injuries that occur at

away events. To provide the best quality and continuity of care, the athlete should report all injuries **PRIOR** to any further participation.

Please refer to the **Melba Sports Medicine webpage** found on the district website for return to participation guidelines following an injury and for more information about the athletic training program. It is important to note the following:

- **Melba Sports Medicine Directing Physician:** Dr. Andrew Curran, D.O., Orthopedic Surgeon primarily based out of ISMI in Boise.
- We also work with the St. Luke's outreach program for help with game coverage as well. From time to time, you will see certified athletic trainers from St. Luke's present at home events.

Please feel free to contact me with any questions you may have. Let's work together to have a successful sports year! Go Mustangs!

Sincerely,

Amy Clark

Amy Clark, LAT/ATC
Melba High School
Sports Medicine Instructor/Athletic Trainer
HOSA Advisor
aclark@melbaschools.org

A FACT SHEET FOR High School Parents

CDC HEADS UP
SAFE BRAIN. STRONGER FUTU

This sheet has information to help protect your teens from concussion or other serious brain injury.

What Is a Concussion?

A concussion is a type of traumatic brain injury—or TBI—caused by a bump, blow, or jolt to the head or by a hit to the body that causes the head and brain to move quickly back and forth. This fast movement can cause the brain to bounce around or twist in the skull, creating chemical changes in the brain and sometimes stretching and damaging the brain cells.

How Can I Help Keep My Teens Safe?

Sports are a great way for teens to stay healthy and can help them do well in school. To help lower your teens' chances of getting a concussion or other serious brain injury, you should:

- Help create a culture of safety for the team.
  - Work with their coach to teach ways to lower the chances of getting a concussion.
  - Emphasize the importance of reporting concussions and taking time to recover from one.
  - Ensure that they follow their coach's rules for safety and the rules of the sport.
  - Tell your teens that you expect them to practice good sportsmanship at all times.
- When appropriate for the sport or activity, teach your teens that they must wear a helmet to lower the chances of the most serious types of brain or head injury. There is no "concussion-proof" helmet. Even with a helmet, it is important for teens to avoid hits to the head.

How Can I Spot a Possible Concussion?

Teens who show or report one or more of the signs and symptoms listed below—or simply say they just "don't feel right" after a bump, blow, or jolt to the head or body—may have a concussion or other serious brain injury.

Signs Observed by Parents

- Appears dazed or stunned
- Forgets an instruction, is confused about an assignment or position, or is unsure of the game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes
- Can't recall events *prior to* or *after* a hit or fall

Symptoms Reported by Teens

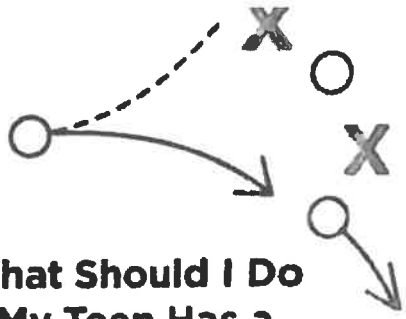
- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness, or double or blurry vision
- Bothered by light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Confusion, or concentration or memory problems
- Just not "feeling right," or "feeling down"

Talk with your teens about concussion. Tell them to report their concussion symptoms to you and their coach right away. Some teens think concussions aren't serious or worry that if they report a concussion they will lose their position on the team or look weak. Remind them that *it's better to miss one game than the whole season.*

CDC

GOOD TEAMMATES KNOW:

CONCUSSIONS AFFECT EACH TEEN DIFFERENTLY.



While most teens with a concussion feel better within a couple of weeks, some will have symptoms for months or longer. Talk with your teens' healthcare provider if their concussion symptoms do not go away or if they get worse after they return to their regular activities.

Plan ahead. What do you want your teen to know about concussion?

What Are Some More Serious Danger Signs to Look Out For?

In rare cases, a dangerous collection of blood (hematoma) may form on the brain after a bump, blow, or jolt to the head or body and can squeeze the brain against the skull. Call 9-1-1, or take your teen to the emergency department right away if, after a bump, blow, or jolt to the head or body, he or she has one or more of these danger signs:

- One pupil larger than the other
- Drowsiness or inability to wake up
- A headache that gets worse and does not go away
- Slurred speech, weakness, numbness, or decreased coordination
- Repeated vomiting or nausea, convulsions or seizures (shaking or twitching)
- Unusual behavior, increased confusion, restlessness, or agitation
- Loss of consciousness (passed out/knocked out). Even a brief loss of consciousness should be taken seriously

What Should I Do If My Teen Has a Possible Concussion?

As a parent, if you think your teen may have a concussion, you should:

1. Remove your teen from play.
2. Keep your teen out of play the day of the injury. Your teen should be seen by a healthcare provider and only return to play with permission from a healthcare provider who is experienced in evaluating for concussion.
3. Ask your teen's healthcare provider for written instructions on helping your teen return to school. You can give the instructions to your teen's school nurse and teacher(s) and return-to-play instructions to the coach and/or athletic trainer.

Do not try to judge the severity of the injury yourself. Only a healthcare provider should assess a teen for a possible concussion. You may not know how serious the concussion is at first, and some symptoms may not show up for hours or days. A teen's return to school and sports should be a gradual process that is carefully managed and monitored by a healthcare provider.

Teens who continue to play while having concussion symptoms or who return to play too soon—while the brain is still healing—have a greater chance of getting another concussion. A repeat concussion that occurs while the brain is still healing from the first injury can be very serious, and can affect a teen for a lifetime. It can even be fatal.

Revised January 2019

To learn more,

ES MEJOR PERDERSE UN JUEGO QUE TODA LA TEMPORADA.

CDC

Las conmociones cerebrales afectan a cada adolescente de manera diferente. Mientras que la mayoría de los adolescentes con una conmoción cerebral se sienten mejor después de un par de semanas, algunos tienen síntomas que duran meses o más tiempo. Hable con el proveedor de atención médica de su adolescente si los síntomas no desaparecen o si empeoran después de que regresa a las actividades normales.

Planifique.

¿Qué quiere que su hijo adolescente sepa sobre las conmociones cerebrales?

¿Cuáles son algunos signos de peligro más graves a los que debo prestar atención?

En raras ocasiones, después de un golpe, impacto o sacudida en la cabeza o en el cuerpo puede acumularse sangre (hematoma) de forma peligrosa en el cerebro y ejercer presión contra el cráneo. Llame al 9-1-1 o lleve a su hijo adolescente a la sala de urgencias de inmediato si después de un golpe, impacto o sacudida en la cabeza o el cuerpo, presenta uno o más de estos signos de riesgo:

- Una pupila más grande que la otra.
- Mareo o no puede despertarse.
- Dolor de cabeza persistente y que además empeora.
- Dificultad de dicción, debilidad, entumecimiento o menor coordinación.
- Naúseas o vómitos, convulsions o ataques (temblores o espasmos) periódicos.
- Comportamiento inusual, mayor confusión, inquietud o nerviosismo.
- Pérdida del conocimiento (desmayado o inconsciente). Incluso una breve pérdida del conocimiento debe considerarse como algo serio.

Usted también puede descargar la aplicación de CDC *HEADS UP* (en inglés) para obtener información a su alcance sobre las conmociones cerebrales. Simplemente scanee con su teléfono celular inteligente el código QR de la imagen a la izquierda.

¿Qué debo hacer si creo que mi hijo adolescente tiene una posible conmoción cerebral?

Como padre, si usted cree que su hijo puede tener una conmoción cerebral, usted debe:

1. Retirarlo del juego.
2. No permitir que regrese a jugar el día de la lesión. Su adolescente debe ver a un proveedor de atención médica y solo podrá regresar a jugar con el permiso de un profesional médico con experiencia en la evaluacion de conmociones cerebrales.
3. Pedirle al proveedor de atención médica de su adolescente que le dé instrucciones por escrito sobre cómo ayudarlo a que regrese a la escuela. Usted puede darle indicaciones a la enfermera de la escuela e intrucciones sobre cómo regresar al juego al entrenador o instructor deportivo.

No trate usted mismo de juzgar la gravedad de la lesión. Solo un proveedor de atención médica debe evaluar a un adolescente de una posible conmoción cerebral. Es posible que al principio usted no sepa qué tan grave es la conmoción cerebral y algunos síntomas pueden tardar horas o días en aparecer. El regreso del adolescente a la escuela y los deportes debe ser un proceso gradual manejado y vigilado por un proveedor de atención médica.

> Los adolescentes que continúan jugando mientras tienen síntomas de conmoción cerebral o que regresan al juego muy temprano, mientras el cerebro todavía se está curando, tienen mayor probabilidad de tener otra conmoción cerebral. Tener otra conmoción cerebral que ocurra mientras el cerebro todavía se está curando de la primera lesión puede ser muy grave y puede afectar al adolescente de por vida; hasta puede ser mortal.

Febrero del 2016

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

Para obtener más información, visite:
www.cdc.gov/headsup/youthsports/index-esp.html

Concussion Paperwork = Everyone (Each Calendar Year)
1 Signed Document per Family (must list Children's Names)
(Pg 7 of 7 - Only return Page 7)

Concussion Information

Parent/Guardian Acknowledgement Form

By signing below, I hereby acknowledge that Melba High School has provided me with the necessary and appropriate education on concussion as mandated under subsection (3) of section 33-1625, Idaho Code. The education included appropriate guidelines and information that identified the signs and symptoms of concussion and head injury, and described the nature and risk of concussion and head injury in accordance with the standards of the Centers for Disease Control and Prevention.

I acknowledge than in addition to receiving the education designated in the above paragraph, that I have had adequate time to review the materials and to have all of my questions addressed by the athletic trainer or other appropriate school personnel. I acknowledge that I understand the nature of concussion, the signs and symptoms of concussion, and the risks of allowing a student athlete to continue to play after sustaining a concussion.

I further understand that Melba School District, the Athletic Trainer and coaches will follow a strict concussion protocol regarding return-to-play. The Athletic Trainer is a certified and licensed healthcare professional who is trained and able to evaluate for a concussion. Any athlete diagnosed with a concussion will work with the Athletic Trainer and/or physician to follow the return-to-play protocol, which is a **minimum of seven days (this is not optional per Idaho Code)**. I understand that the Athletic Trainer can answer any questions regarding the policy or protocol.

_____

Student(s) Name (Please Print)

_____ _____ _____

Parent/Guardian Name (Please Print) Parent/Guardian Signature Date