

TAPPS PREPARTICIPATION PHYSICAL EVALUATION

STUDENT'S FULL NAME: _____ **GRADE LEVEL:** 9 10 11 12
GENDER: Male / Female **AGE:** _____ **DATE OF BIRTH:** ____/____/_____
HEIGHT: ____feet ____inches **WEIGHT:** _____ **% BODY FAT:** _____%
PULSE: _____ **BLOOD PRESSURE:** ____/____ **BRACHIAL BP WHILE SITTING:** ____/____, ____/____

In keeping with the requirements of the Texas Association of Private and Parochial Schools (TAPPS), the physical examination form must be completed prior entrance to high school and prior to athletic participation each year. The form is good for one year from the date of physician signature shown below.

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
Appearance			
Eyes / Ears / Nose / Throat			
Lymph Nodes			
Heart – Auscultation of the heart in supine position			
Heart – Auscultation of the heart in standing position			
Heart – Lower Extremity Pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (Males Only)			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hyper mobility, or scoliosis)			
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
Neck			
Back			
Shoulder / Arm			
Elbow / Forearm			
Wrist / Hand			
Hip / Thigh			
Knee			
Leg / Ankle			
Foot			
Other as noted			

*station-based examination only

Clearance:

Cleared for all participation.

Cleared after completing rehabilitation / examination for: _____

Not cleared for: _____ Reason: _____

Recommendations:

Provider Name: _____ **Provider Address:** _____
Provider Signature: _____ **Date of Examination:** ____/____/____

TAPPS MEDICAL HISTORY FORM

This Medical History Form must be completed annually by the parent (or guardian) and student in order for the student to participate in TAPPS athletic and selected fine art activities. These questions are designed to assist the practitioner in determining if the student has developed any condition which would make it hazardous to participate in an extracurricular activity.

STUDENT NAME: _____ **GRADE LEVEL:** 9 10 11 12
GENDER: Male / Female **AGE:** _____ **DATE OF BIRTH:** ____/____/_____
HOME ADDRESS: _____ **CONTACT PHONE #:** (____) ____ - ____
PERSONAL PHYSICIAN: _____ **PHYSICIAN PHONE #:** (____) ____ - _____

If the answer to any question is yes, please discuss the circumstances with your provider at the time of the physical examination.

	YES	NO	UNKNOWN
Have you had a medical illness or injury since your last physical?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been hospitalized overnight in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had prior testing ordered by a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chest pains during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get tired more quickly than your friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had your racing of your heart?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had your heart skip beats?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has any member of your biological family died of heart problems or sudden unexplained death prior to the age of 50?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has any biological family member been diagnosed with an enlarged heart (dilated Cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome, or other ion Channelopathy (Brugada Syndrome, etc), Marfan's Syndrome or abnormal heart rhythm?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a severe viral infection (such as myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TAPPS MEDICAL HISTORY FORM

	YES	NO	UNKNOWN
Has a physician ever denied or restricted your participation in extracurricular activities for any heart related problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a diagnosed head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been knocked out, become unconscious or lost memories?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes to the question above, how many times? _____			
If yes, when was your last diagnosed concussion? ___/___/_____			
If Yes, how severe were each of the concussions? Discuss with the Provider			
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"/>
Have you been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been unexpectedly short of breath while exercising?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed by a physician with asthma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have seasonal allergies which require medical attention or treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you missing any paired organs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you presently under a doctor's care for any condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently taking any prescription or nonprescription medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you presently using an inhaler, prescribed or nonprescribed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any known allergies (pollen, medicine, food or insects)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have current skin problems (examples: itching, rashes, acne, warts, blisters or fungus)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you want to weigh more or less than you do today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been diagnosed with or treated by a physician for sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TAPPS MEDICAL HISTORY FORM

YES NO UNKNOWN

Do you use any special protective or corrective equipment that are not usually used for your particular activities (examples: knee brace, neck roll, foot orthotics, retainer, prescription goggles or hearing aid)?

Have you ever had swelling after a sprain, strain or injury?

YES NO UNKNOWN

Have you ever broken or fractured any bones or dislocated any joints?

Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? If yes, please check each box below that applies.

HEAD	<input type="checkbox"/>	ELBOW	<input type="checkbox"/>	HIP	<input type="checkbox"/>
NECK	<input type="checkbox"/>	FOREARM	<input type="checkbox"/>	THIGH	<input type="checkbox"/>
BACK	<input type="checkbox"/>	WRIST	<input type="checkbox"/>	KNEE	<input type="checkbox"/>
CHEST	<input type="checkbox"/>	HAND	<input type="checkbox"/>	SHIN / CALF	<input type="checkbox"/>
SHOULDER	<input type="checkbox"/>	FINGER	<input type="checkbox"/>	ANKLE	<input type="checkbox"/>
UPPER ARM	<input type="checkbox"/>	FOOT	<input type="checkbox"/>		

Female Students Only (If left blank I agree to provide such information to the provider at the time of examination)

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? _____ days

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

How many periods have you had in the last year?

Male Students Only (If left blank I agree to provide such information to the provider at the time of examination)

Are you missing a testicle? YES NO

Do you have any testicular pain? YES NO

Do you have any testicular swelling or masses? YES NO

TAPPS MEDICAL HISTORY FORM

It is understood that even though protective equipment is worn by the student participant, whenever needed and as prescribed, the possibility of accident or injury still remains. Neither the Texas Association of Private and Parochial Schools (TAPPS) nor the TAPPS member school assumes any responsibility should injury occur.

If in the judgement of any representative of the school the student should need immediate care and / or treatment as a result of any injury or illness, I do hereby request, authorize and consent to such care and treatment as may be given to said student by any physician, athletic trainer, nurse or designated school representative. I do hereby indemnify and save harmless the TAPPS member school, TAPPS, treating medical establishment and representatives of each from any claim by any on account of such care and treatment of said student.

If, between the date affixed to this document and the beginning of extracurricular training, competition, or performance any injury or illness should occur that may limit the student's participation, I agree to promptly notify the recognized and designated authority at the member school of such injury or illness.

I hereby state that to the best of my knowledge, my answers to the questions asked on this form are complete and correct. I understand that failure to provide truthful and complete responses could subject the student to nonparticipation at the member school and penalties as determined by TAPPS.

Student Full Name: _____

Student Signature: _____

Date of Signature: ____ / ____ / ____

Parent / Guardian Name: _____

Parent / Guardian Signature: _____

Date of Signature: ____ / ____ / ____

BRACKEN CHRISTIAN SCHOOL ATHLETIC DEPARTMENT

ATHLETIC PARTICIPATION CONTRACT

2024-25

This participation contract must be filled out completely and turned into the Athletic Department before the athlete can participate in any athletic competitions. The purpose of this form is to emphasize the seriousness of committing to play for a team and that once a commitment is given, every possible effort needs to be made in order to fulfill that commitment.

Name of Athlete: _____ Grade: _____

The above listed athlete agrees to the following conditions/rules of participation:

Once this form is signed and returned, the athlete is promising to fulfill their commitment to any team that they try out for as long as that season lasts. Failure to fulfill this commitment, which in the case is finishing the season in good standing with the team, will result in the athlete losing all eligibility in Bracken Christian School athletics for one calendar year. The only exceptions to this rule are extended/sever medical conditions that arise during the season or an exceptionally difficult family emergency that must be dealt with over a period of time.

Examples of situations that are NOT accepted reasons for quitting a team:

- Any school-related function not cleared prior to the season (banquets, drama production, etc)
- Needing a job
- Attending drivers education
- Lack of playing time
- Too difficult to get to practice
- It is not fun anymore
- Needing to concentrate on academics
- Too much other stuff to do
- Etc

As much as these reasons may be legitimate concerns for many athletes, they are all things that need to be considered **before** a student commits to playing on a team. Athletics is a very time-consuming event and athletes and parents need to understand this in advance.

It is our goal to teach our students Christ-like attributes in everything that we do at Bracken Christian School. We feel that responsibility, integrity, loyalty, and honoring commitment, are all attributes that we are trying to instill by enforcing this policy. We appreciate everyone's understanding as we try to better prepare our students for His service.

Parent Signature: _____ **Date:** _____

Athletes Signature: _____ **Date:** _____

BRACKEN CHRISTIAN SCHOOL ATHLETIC DEPARTMENT

TRANSPORTATION FORM

2024-25

This form needs to be filled out and on file in the athletic office for all student athletes within the Bracken Christian School athletic department. Students will not be allowed to participate in games away from Bracken Christian School without this form being on file.

Student Name: _____ Grade: _____

MIDDLE SCHOOL AND HIGH SCHOOL (check all boxes that are applicable)

_____ I give permission for my child to ride on the school bus (if available and/or offered)

_____ I will be responsible for getting my child to and from all athletic events in which transportation is not provided by the school.

_____ I give my child permission to ride with another parent to events.

_____ I give my permission for my child to ride to events and with a designated student driver (HS only)

_____ I will be willing to help drive students to games, and I normally have room for _____ additional students.

_____ I would be willing to help arrange and coordinate transportation needs for a given sport.

Please note: Bracken Christian School does offer bus transportation to many athletic events. However, due to both the number of teams participating on a given day or the number of players on a given team, transportation may not always be available for a particular event or team. In those cases in which bus transportation is not available, it is the responsibility of the parent to arrange transportation for their student in a timeliness consistent with the teams daily schedule.

STUDENT DRIVE INFORMATION (High School Only)

_____ I give permission for my child to drive his/her own car to events (No additional riders).

_____ I give permission for my child to drive his/her own car to games and to take other students.

_____ I give my child permission to ride with the following student drivers:

List:

Parent Name: _____ Parent Signature: _____

Parents' Information Regarding Bracken Christian School 2024-25 Voluntary Accident Insurance Program Coverage Selections and Enrollment Form

Bracken Christian School does NOT assume financial responsibility for injuries sustained while attending school and participating or practicing in school-sponsored and supervised extracurricular activities and sports. A parent or guardian does however have the option to purchase ACCIDENT-ONLY insurance and it covers injuries sustained while attending school and participating in school-sponsored and supervised extracurricular activities and sports (except football grades 9-12). There is also a Full-Time (24-hour) Coverage option which extends coverage for accidents that occur away from school on a 24-hours per day basis. A schedule of the plan benefits and exclusions under the three voluntary plans offered. Coverage is available on or after July 1, 2019. The voluntary plan options exclude interscholastic football for students in grades 9-12. **▲ STUDENT ATHLETE MUST BE COVERED BY OWN POLICY OR ACCIDENT INSURANCE POLICY.**

I acknowledge that I have been given the opportunity to review the enrollment, benefits and exclusions of the Voluntary Accident insurance coverage available. I understand that it is my responsibility to enroll in the voluntary accident plan and submit payment directly to Student Assurance Services, Inc. and insurance coverage is not effective until 12:01 following the date the enrollment form and payment is received by Student Assurance Services, Inc.

VOLUNTARY COVERAGE OPTIONS

School-Time Coverage PK-12 Includes TAPPS Activities and Sports 7-12 (Does Not include students participating in 9-12 interscholastic football)

Covers the student while:

- a. Attending regular school sessions.
- a. Participating in or attending school-sponsored and supervised extracurricular activities;
- b. Participating for or participating in school-sponsored and supervised TAPPS sports and activities for grades 7-12 (except football grades 9-12) and
- c. Traveling directly to and from school for regular school sessions, and while traveling to and from school-sponsored and supervised extracurricular and TAPPS sports and activities in school-provided transportation.

Full-Time Coverage PK-12 includes TAPPS Activities and Sports 7-12 (Does not include students participating in 9-12 interscholastic football)

Covers the student 24 hours per day until school starts next year. Includes coverage while at home and school, on weekends, and during summer vacation. Covers students while practicing or participating in school-sponsored and supervised TAPPS activities and sports, including travel in school-provided transportation for grades 7-12 (except football grades 9-12).

Extended Dental Coverage PK-12

Provides up to \$5,000 in benefits for any dental accident and covers the student 24 hours a day until school starts next year. Treatment must begin within 180 days from the date of injury. Benefits are limited to expenses actually incurred within one year from the date of accident. However, if within the one-year period following the date of accident the insured's attending dentist certifies that dental treatment and/or replacement must be deferred beyond one year, the plan will pay the estimated cost of such deferred treatment, but not exceed \$200 for each tooth. No benefits will be allowed for orthodontics or dental disease and benefits for prostheses are limited to \$500 per injury including procedures to install them. Dental prostheses include, but are not limited to crowns, dentures, bridges, and implants. Extended Dental does not cover treatment for orthodontics, dental disease, or expenses that exceed the prostheses maximum benefit limit.

HOW TO ENROLL:

For credit card payment, complete the online enrollment form at the website: www.texaskidsfirst.com. Students/Parents select "Find My School" from the drop down box select "Texas" and then select Bracken Christian School

I waive the option to purchase accident insurance as I have my own insurance provided below: (please provide copy of card)

Student name(s): _____ Grade(s): _____

Medical Insurance Policy Name: _____

Policy Number: _____

Parent Signature and Date: _____