APPLICATION FOR PARTICIPATION IN AGOURA STINGRAYS/SHARKS

[ ] Check If **NEW** Athlete (Never participated in Agoura Stingrays/Sharks before)

ELIGIBILITY FOR PARTICIPATION IN AGOURA STINGRAYS/SHARKS : Every person with Intellectual Disabilities is eligible to participate in Agoura Stingrays/Sharks . A person is considered to have Intellectual Disabilities if that person satisfies any one of the following requirements: 1) person has been identified by an agency or professional as having Intellectual Disabilities, 2) person has a cognitive delay, as determined by standardized measures such as intelligent quotient or "IQ" testing or other measures which are generally accepted as being a reliable measurement of the existence of a cognitive delay, or 3) person has a closely related developmental disability. A "closely related developmental disability" means having functional limitations in both general learning (such as IQ) and in adaptive skills (such as in recreation, work, independent living, or self-care). Persons whose functional limitations are based solely on a physical, behavioral, emotional disability, or a specific learning or sensory disability are not eligible to participate in Agoura Stingrays/Sharks .

SECTION A – ATHLETE INFORMATION *Required once every three (3) years for all athletes.*

Please print clearly in blue or black ink.

REGION/AREA/LOCAL PROGRAM: _____ YEAR STARTED IN AGOURA STINGRAYS/SHARKS : _____

ATHLETE INFORMATION

ATHLETE NAME: (LAST)_____ (FIRST)_____ (NICKNAME)_____

DATE OF BIRTH (month/day/year): _____ / _____ / _____

GENDER (circle): Male Female

ADDRESS: _____(APT/STE)_____ HOME PHONE: (_____) _____

CITY: _____ STATE: _____ ZIP: _____ MOBILE PHONE: (_____)_____

EMAIL: _____

HEALTH INSURANCE COMPANY: _____ POLICY #: _____

ETHNIC BACKGROUND: African Amer.☞ [ ] Anglo☞ [ ] Asian/Pacific Islands☞ [ ] Hispanic☞ [ ] Native Amer.☞ [ ] Other not listed☞ [ ] _____

ATHLETE EMPLOYMENT INFORMATION

EMPLOYER: _____ WORK PHONE: (_____)_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PARENT/GUARDIAN INFORMATION

PARENT/GUARDIAN NAME: _____ HOME PHONE: (_____) _____

ADDRESS: _____ MOBILE PHONE: (_____) _____

CITY: _____ STATE: _____ ZIP: _____ WORK PHONE: (_____) _____

EMAIL: _____

PARENT/GUARDIAN EMPLOYMENT INFORMATION

EMPLOYER: _____ EMPLOYER PHONE: (_____)_____

ADDRESS: _____

CITY: _____ STATE: _____ Zip: _____

EMERGENCY CONTACT INFORMATION

CONTACT: _____ RELATIONSHIP: _____

HOME PHONE: (_____) _____ MOBILE PHONE: (_____) _____

FOR OFFICE USE ONLY

Date Received: _____	**Verified by:** _____

SECTION B – ATHLETE HEALTH INFORMATION *Required once every three (3) years for all athletes.*

Please print clearly in blue or black ink.

MEDICAL HISTORY

IMPORTANT: Any significant change in the athlete's health or condition should be reviewed by a licensed examiner before further participation.

		Yes	No	New Problem
1.	Heart Disease/Heart Defect/High Blood Pressure	☐	☐	
2.	Chest Pain or Fainting Spells	☐	☐	
3.	Seizures/Epilepsy	☐	☐	
4.	Diabetes	☐	☐	
5.	Down Syndrome	☐	☐	
	Have cervical spine (neck bone) x-rays been done	☐	☐	
	Atlanto Axial Instability	☐	☐	
6.	Parent/Sibling (under 40) died of heart disease	☐	☐	☐
7.	Absence of one kidney or testicle	☐	☐	☐
8.	Concussion or serious head injury	☐	☐	☐
9.	Major surgery or serious illness	☐	☐	☐
10.	Heat stroke/exhaustion	☐	☐	☐
11.	Other problem that would interfere w/ sports participation	☐	☐	
	List _____			
12.	Impaired motor ability	☐	☐	
13.	Uses a wheelchair	☐	☐	

		Yes	No
14.	Allergy to the following (be specific)	☐	☐
	Medicine _____	☐	☐
	Foods _____	☐	☐
	Insect Sting/Bite _____	☐	☐
15.	Special Diet _____	☐	☐
16.	Exercise induced wheezing	☐	☐
17.	Tendency to bleed easily	☐	☐
18.	Emotional/psychiatric/behavioral problems	☐	☐
19.	Serious bone or joint disorder	☐	☐
20.	Sickle cell trait or disease	☐	☐
21.	Hearing aid/hearing loss	☐	☐
22.	Contact lenses/eyeglasses	☐	☐
23.	Dentures/false teeth	☐	☐
24.	Immunizations (shots) are up-to-date	☐	☐
25.	Date of last tetanus shot _____ / _____ / _____		

ADDITIONAL COMMENTS

_____

_____

_____

MEDICATIONS Please print medication name, amount, date prescribed and number of times per day medication needs to be taken

_____

_____

_____

_____

PERSON COMPLETING FORM (normally parent/guardian or adult athlete) _____ _____

Signature Date

IF HISTORY SIGNED BY ADULT ATHLETE – I have reviewed the health history with the athlete whose signature appears above

_____ _____ _____

Signature Date Relationship to athlete (family member, friends, coach)

SECTION C - MEDICAL CERTIFICATION *Required once every three (3) years for all athletes.*

MUST BE PERFORMED AND COMPLETED BY A LICENSED MEDICAL EXAMINER (PHYSICIAN, PHYSICIAN ASSISTANT, OR CHIROPRACTOR)

EXAMINER'S NOTE: If the athlete has Down Syndrome, the Agoura Aquatics Foundation requires a full radiological examination establishing the absence of Atlanto-Axial Instability before he/she may participate in sports or events which, by their nature may result in hyperextension, radical flexion or direct pressure on the neck or upper spine. The sports and events for which such a radiological examination is required are: gymnastics, pentathlon, butterfly stroke in aquatics, diving start in aquatics, high jump, & soccer (football).

BRIEF EXAM: HT _____ WT: _____ PULSE: _____ B.P. _____ ENT: _____ HEART: _____ LUNGS: _____

☐ I have reviewed the above health information and examined the athlete named in the application, and certify there is no medical reason available to me which would preclude the athlete's participation in Agoura Stingrays/Sharks.

RESTRICTIONS _____

Examiner's Signature _____ Date: _____

Examiner's Name _____ Phone (_____) _____

Address _____ City _____ Zip _____