HOLD HARMLESS AGREEMENT

I, _____ (Parent/Guardian), on this date _____, hereby affirm my

child,)_____, shall be a student of San Marcos Baptist Academy (SMA) and will be participating in school sponsored activities (e.g. athletic, academic, and recreational) hereinafter referred to as “The Activities.”

I understand that SMA activities have inherent risks, I expressly represent that I have consulted with my and/or my minor child's physician(s) who verified and determined that my minor child is physically able to participate in “The Activities” offered by SMA, on or off premises.

In consideration for being able to enroll and participate in “The Activities,” and acting on behalf of myself and my minor child, I hereby assume all risks and hazards associated with participation in “The Activities” (this might include football, baseball, softball, swimming, basketball, soccer, volleyball, tennis, weight lifting, cross country, golf, horseback riding, ropes course, bicycling, and related events sponsored by the Student Activities Department).

VOLUNTARY RELEASE OF LIABILITY AND INDEMNITY:
Acting on behalf of myself and my minor child, I agree to release, hold harmless, defend and indemnify San Marcos Baptist Academy, its agents, assistants, employees and co-sponsors including but not limited to: San Marcos Academy and their respective employees or agents, officers, and directors (the “released parties”) for any damage or injuries, physical or mental, including those caused in whole or in part by the negligence of any released party, which I or my minor child might incur as a result of my voluntary decision to participate in the "The Activities."

I further agree to release, hold harmless, defend and indemnify the released parties and each of them from any claim brought by a third party, including a co-participant, for any injury or loss suffered by that person caused in whole or in part by the actions of my child or myself.

_____ _____

Name of Parent or Guardian Signature of Parent or Guardian

ANNUAL PRE-PARTICIPATION - PHYSICAL EXAMINATION

Student's Name _____ Sex _____ Age _____ Date of Birth: _____
Height _____ Weight _____ % Body fat (optional) _____ Pulse _____ BP____/_____ (_____/_____,_____/_____)
brachial blood pressure while sitting
Vision R 20/_____ L 20/_____ Corrected: □Y ___ □N ___ Pupils: □Equal ___ □Unequal ___

THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY ACTIVITIES BEFORE, DURING OR AFTER SCHOOL. TO BE CURRENT, A PHYSICAL MUST BE DATED WITHIN THREE MONTHS OF THE STUDENT'S ARRIVAL ON CAMPUS.

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in the supine position.			
Heart-Auscultation of the heart in the standing position.			
Heart-Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			

MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*station-based examination only

CLEARANCE

__ Cleared for school activity/athletic participation.
__ Cleared after completing evaluation/rehabilitation for: _____
_____
_____

Not cleared for: _____ Reason: _____
Recommendations: _____
_____

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners or a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners. Examination forms signed by any other health care practitioners will not be accepted.

Physician Name (print/type) _____ **Date of Examination:** _____

Address:_____

Phone Number: _____

Physician Signature:_____

PRE-PARTICIPATION - MEDICAL HISTORY

THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY ACTIVITIES BEFORE, DURING OR AFTER SCHOOL.

This **PRE-PARTICIPATION MEDICAL HISTORY form must be completed *annually*** by parent (or guardian) and student in order for the student to participate in activities/athletics. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in school activities and/or athletic events.

Student's Name: _____Sex: _____Age: _____Date of Birth: _____

Address: _____

Phone: _____ Grade: _____

Previous School: _____

Personal Physician: _____ Phone : _____

In case of emergency, contact:

Name: _____ Relationship: _____

Phone: (Home)_____ (Work)_____(Cell)_____

Explain any "Yes" answers in the box on page 2.** Circle questions you don't know the answers to. **Any Yes answer to questions 1 - 23 must be specifically addressed by the physician, physician assistant, or nurse practitioner performing the Physical Examination.**

Condition or Medical Event	Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?		
2. Have you been hospitalized overnight in the past year?		
3. Have you ever had surgery?		
4. Have you ever passed out during or after exercise?		
5. Have you ever had chest pain during or after exercise?		
6. Do you get tired more quickly than your friends do during exercise?		
7. Have you ever had racing of your heart or skipped heartbeats?		
8. Have you had high blood pressure or high cholesterol?		
9. Have you ever been told you have a heart murmur?		
10. Has any family member or relative died of heart problems or of sudden unexpected death before age 50?		
11. Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome or other ion channelpathy (Brugada syndrome, etc), Marfan's syndrome, or abnormal heart rhythm?		
12. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?		
13. Has a physician ever denied or restricted your participation in sports for any heart problems?		
14. Have you ever had a head injury or concussion?		
15. Have you ever been knocked out, became unconscious, or lost your memory? If yes, how many times? _____ When was the last concussion? _____		
16. How severe was each one? (Explain below**)		
17. Have you ever had a seizure?		
18. Do you have frequent or severe headaches?		
19. Have you ever had numbness or tingling in your arms, hands, legs or feet?		
20. Have you ever had a stinger, burner, or pinched nerve?		
21. Are you missing any paired organs?		
22. Are you under a doctor's care?		
23. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?		
24. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?		
25. Have you ever been dizzy during or after exercise?		
26. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?		
27. Have you ever become ill from exercising in the heat?		

Condition or Medical Event	Yes	No
28. Have you had any problems with your eyes or vision?		
30. Have you ever gotten unexpectedly short of breath with exercise?		
31. Do you have asthma?		
32. Do you have seasonal allergies that require medical treatment?		
33. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?		
34. Have you ever had a sprain, strain, or swelling after injury?		
35. Have you broken or fractured any bones or dislocated any joints?		
36. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? If yes, check and explain below.		
__ Head __ Neck __ Back __ Chest __ Shoulder __ Upper Arm __ Elbow __ Forearm __ Wrist __ Hand __ Finger __ Hip __ Thigh __ Knee __ Shin/Calf __ Ankle __ Foot		
37. Do you want to weigh more or less than you do now?		
38. Do you lose weight regularly to meet weight requirements for your sport?		
39. Do you feel stressed out?		
40. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?		

Females Only

41. When was your first menstrual period?	
42. When was your most recent menstrual period?	
43. How much time do you usually have from the start of one period to the start of another?	
44. How many periods have you had in the last year?	
45. What was the longest time between periods in the last year?	

An individual answering "Yes" to any question relating to a possible cardiovascular health issue (question 4-13 above), as identified on the form, should be restricted from further participation until the individual is examined and cleared by a physician, physician assistant, chiropractor, or nurse practitioner.

****EXPLAIN 'YES' ANSWERS IN THE BOX BELOW*** **(attach another sheet if necessary):**

_____
_____
_____
_____
_____
_____

It is understood that even though protective equipment is worn by the athlete, the possibility of an accident still remains. Neither TAPPS nor San Marcos Baptist Academy assumes any responsibility in case an accident occurs.

If, in the judgment of any representative of SMBA, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student.

If, between this date and the beginning of athletic competition, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide truthful responses could subject the student in question to penalties determined by San Marcos Baptist Academy.

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

AUTHORIZATION TO DISPENSE, MONITOR AND TRANSPORT PRESCRIPTION MEDICATIONS and MONITOR MEDICAL DIAGNOSES

I. This section to be completed by the child's <u>ATTENDING PHYSICIAN</u>:

My patient, _____, is prescribed the following medication(s) and dosages:
Printed Name
Please also indicate the **frequency** for each dosage … **"E" for EVERYDAY or "S" for SCHOOL DAYS ONLY**

#	Name of Medication	Dosage	When Taken	Frequency	How long has student taken this medication
1					
2					
3					
4					
5					

Diagnosis: _____

Restrictions: _____

_____ _____ _____ _____
Printed Name of Attending Physician **Signature of Attending Physician** **Telephone Number** **Date**

II. This section to be completed by <u>PARENT/GUARDIAN</u>: _____ has my permission to receive the medication(s) listed above while at school, according to the standard policies. I understand that this information will be kept confidential and will be given to others at SMA only when needed for the care of my child. <u>All medications must be delivered to the Infirmary in their ORIGINAL containers.</u>

_____ _____ _____ _____
Printed Name of Parent/Guardian Signature of Parent/Guardian Relationship to Student Date

PARENTAL PERMISSION TO TRANSPORT MEDICATION

As the parent or guardian of _____, I give permission for this student to personally transport his/her medications for: _____ Vacations/Holidays _____ Long Leave Weekends _____ Traveling off Campus

_____ _____
Parent/Guardian Signature Date

SAN MARCOS BAPTIST ACADEMY

AUTHORIZATION FOR MEDICAL TREATMENT

I hereby authorize any official representative of San Marcos Baptist Academy to admit or to sign documents necessary for the admission of the individual named below to any medical hospital, mental health facility or emergency care unit when deemed necessary by Academy personnel. I also authorize the administration of immunizations, TB skin tests, medical/drug tests and/or any non-emergency, routine doctor visits that may be recommended by the Academy physician or personnel.

I further understand that if medical or mental health attention should become necessary for the health and well-being of the student, that I, the parent or guardian, am solely responsible for payment of these items. I further authorize San Marcos Baptist Academy to provide my health insurance information to any health care provider as payment for services. If my insurance is declined for any reason or authorization is not granted, the Academy will issue payment directly to such provider and bill my Academy account plus a 10% service charge per transaction.

_____ _____

Print Name of Student **Student Date of Birth**

_____ _____

Print Name of Parent or Guardian **Signature of Parent or Guardian**

IMMUNIZATION REQUIREMENTS

A student shall show acceptable evidence (month) (date) (year) for all vaccinations.

All Students, Grades Fourth through Twelve:

- ✓ 3 doses of DTP, Dtap, DT with one on or after 4th birthday.
- ✓ 1 dose Tdap is required within the last 5 years.
  - Td is acceptable in lieu of Tdap if a contraindication to pertussis exists.
- ✓ 4 doses of Polio with one on or after 4th birthday. OR 3 doses if one dose is on or after 4th birthday.
- ✓ 2 doses of MMR after 1st birthday.
- ✓ 3 doses of Hepatitis B.
- ✓ 2 doses of Varicella on or after 1st birthday (if the child has not had the chickenpox disease).
  - (For the chickenpox disease we accept either the parent's statement of month and year or a doctor's proof of confirmation.)
- ✓ 1 dose of Meningitis (ACYW-135) *This is not required for Fourth through Sixth graders*
- ✓ **Fourth through Eighth Graders Only**: two doses of Hepatitis A

Student Name: _____ DOB: _____

Record of Immunizations	1ST	2ND	3RD	4TH	5TH
Polio	/ /	/ /	/ /	/ /	/ /
DTP, Dtap, DT/TD (Diphtheria/Tetanus/Pertussis)	/ /	/ /	/ /	/ /	/ /
Tdap **(Tetanus, diphtheria & Pertussis)**	/ /	/ /	/ /		
Hepatitis B	/ /	/ /	/ /		
Hepatitis A	/ /	/ /			
MMR	/ /	/ /			
Chickenpox (varicella)	/ /	/ /			
Chickenpox Disease	Month:		Year:		
Meningitis (ACYW-135)	/ /				

The minimum requirement upon arrival for NEW International Students is completion of the first Series of Vaccines listed above and a Tuberculosis screening.

TUBERCULIN TESTS: Skin Test (Required) Date given: _____ Date Read: _____ mm: _____

Chest X-ray (required if Skin Test is 10mm or greater): Date: _____ Results: _____

Physician Signature: _____ Date: _____

After arriving at the Academy, if the skin test is 10 mm or greater, the student is required to have a Quanti Feron Blood Test preformed at our local clinical laboratory.

The cost of this test or any administration of required vaccines needed will be billed to the student's account if not covered by the student's insurance.

MENTAL HEALTH INFORMATION

Please complete the following form if your student is under the care of a mental health professional.

Student Name: _____

This section to be completed by <u>Parent/Guardian</u>:

1. Is your child currently seeing a therapist (counselor/psychologist)? _____ No _____ Yes

   If Yes . . .
   Therapist's Name: _____

   Telephone: _____ Office Address: _____

   How long has your child seen this therapist? _____

   How often do they currently see this therapist? _____

   Will they continue to see this therapist while attending SMA? _____

   Diagnosis or diagnoses:

   _____ _____

   _____ _____

2. Is your child currently seeing a psychiatrist? _____ No _____ Yes

   If Yes . . .
   Psychiatrist's Name: _____

   Telephone: _____ Office Address: _____

   How long has your child seen this psychiatrist? _____

   How often do they currently see this psychiatrist? _____

   Will they continue to see this psychiatrist while attending SMA? _____

   Diagnosis or diagnoses:

   _____ _____

   _____ _____

3. Will you need a referral for your child to start meeting with a new therapist or psychiatrist while attending SMA? _____ No _____ Yes

4. In order to ensure continuity of care, I hereby grant permission for the above referenced therapist/psychiatrist to release information to the Mental Health Counselor at San Marcos Academy, and for the San Marcos Academy Mental Health Counselor to share information with the above referenced therapist/psychiatrist.

_____	_____	_____	_____
Printed Name of Parent/ Guardian	Signature	Relationship to Student	Date

SMA Application for Automobile Riding/Driving Privileges

Student Name: _____ Grade: _____ Date of Application: _____

Levels and disciplinary issues will affect vehicle usage or rider privileges.

I. Being transported by other students within legal limits (Rider Permission)*

Select one by placing your initials in the blank.

____ My student may **not** ride with any SMA student without my written permission.
____ My student may ride **only** with the following SMA students: (please include FULL name) _____
_____
____ My student may ride with students in their vehicles with no restrictions other than levels.

II. Vehicle on Campus

Only 11th & 12th grade students have vehicle privileges. This includes riding or driving in vehicles without specific permission from the Associate Academic Dean or Dean of Residential life and the parent.

The undersigned requests permission to maintain and drive an automobile on the San Marcos Academy campus. Approval is contingent on behavior and academic standing as well as the previous year's driving record if applicable. Maintaining an automobile on campus is a privilege that may be forfeited temporarily or permanently for violations of Academy driving rules.

Select one by placing your initials in the blank.

____ My vehicle will be used to drive to my home only.
____ My vehicle will be used to drive to my home and/or in the environs of San Marcos (10 mile radius of campus).*
____ My vehicle may be used to drive wherever my parents and Hall Director have given permission.*

Automobile Make _____ Model _____ Year _____ Color _____

Vehicle License Tag (State & #) _____ SMA Parking Decal issue date _____

Insurance Company _____ Policy Number _____ Expiration Date _____

Student Driver's License # _____ State ____ Expiration Date _____ Driver's License Restrictions _____

III. Transportation of other students within legal limits (Driver Permission)*

Select one by placing your initials in the blank.

____ My student may **not** transport any other students in his/her vehicle.
____ My student may transport only one other student in his/her vehicle with no restrictions other than levels.
____ My student may transport other students in his/her vehicle with no restrictions other than levels.
____ My student may transport the following persons: (please include FULL names) _____

The undersigned realizes that the above activities might entail some degree of danger. In consideration of the premises, the undersigned hereby releases San Marcos Academy of and from any claims or causes of action which the undersigned might have against it by reason of any injury to or death of the above named student by reason of such activities; and the undersigned does hereby agree to indemnify and hold harmless San Marcos Academy from any and all claims, demands, or causes of action whatsoever which might be subjected by reason of an injury or death of the above named student by reason of engaging in the above mentioned activities. The Academy is not responsible for the continued verification of Drivers License, safety inspection, or insurance status for its students and their vehicles.

_____ _____
Parent/Guardian Signature **Student Signature**

*** Final Riding/Driving Privilege decisions rest with Academy administration.**

☐ Approved ☐ Disapproved

_____ _____
Associate Dean (Day Students) or Dean of Boys/Dean of Girls (Boarding Students) **Date**