



GUAM DEPARTMENT OF EDUCATION  
 INTERSCHOLASTIC ATHLETIC ASSOCIATION  
**ATHLETE PACKET**

**SY 2024-2025**

ATHLETES NAME: \_\_\_\_\_  
 (Print Neatly Please)

STUDENT#: \_\_\_\_\_ Birth Date \_\_\_\_\_

GRADE: \_\_\_\_\_ DATE \_\_\_\_\_

**Put a X with each sport you want to participate in.**

1 <sup>st</sup> QUARTER (check one)	2 <sup>nd</sup> QUARTER (check one)	3 <sup>rd</sup> QUARTER (check one)	4 <sup>th</sup> QUARTER (check one)
// GIRLS VOLLEYBALL	// FOOTBALL	// BOYS/GIRLS RUGBY	// TRACK AND FIELD
// CROSS COUNTRY	// PADDLING	// BOYS BASKETBALL	// BASEBALL
// WRESTLING	// GIRLS BASKETBALL	// SOFTBALL	// GIRLS SOCCER
// BOY'S SOCCER	// CHEER	// TENNIS	// BOYS VOLLEYBALL
// CHEER		// CHEER	// CHEER

FORM 1 OF 5





MEDICAL CLEARANCE FORM 2 OF 5 (4 PAGES)

Department of Education  
PARENTAL & PHYSICAL  
EXAM FORM SECONDARY



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

<b>Student:</b>		<b>DOB:</b>	
<input type="checkbox"/> Male	<input type="checkbox"/> Female	Grade: _____	
Home Address: _____			
<b>Father/Guardian:</b>		<b>Mother/Guardian:</b>	
Place of work: _____		Place of work: _____	
Phone: Home: _____	Work: _____	Phone: Home: _____	Work: _____
Cell: _____		Cell: _____	
Email: _____		Email: _____	

**PART I:  
IMMUNIZATION AND TB STATUS:**

A copy of the **Official Immunization Record** must on record with the school nurse. Records must indicate the specific immunizations and the result of a **TB Skin Test** with date when received. Refer to **Board Policy 337** for specific health requirements and **SOP 1200-020**.

**TO BE COMPLETED BY PARENTS (before appointment):**

**Health History:** *Please indicate age and/or year on past and current medical conditions:*

1.	Anemia		9.	Heart Disease	
2.	Asthma		10.	Hernia	
3.	Chickenpox		11.	Mumps	
4.	Convulsions/Seizure		12.	Rheumatic Fever	
5.	Diabetes		13.	Skin Disorder	
6.	Measles		14.	Tuberculosis	
7.	Hay Fever		15.	Vision	
8.	Hearing		16.	Other	

**Please complete and provide additional information at the back:**

17.	Head Injuries <input type="checkbox"/> Yes <input type="checkbox"/> No	Year: _____	Results: _____
18.	Fractures, broken bone(s) <input type="checkbox"/> Yes <input type="checkbox"/> No	Year: _____	Results: _____
19.	Previous hospitalization <input type="checkbox"/> Yes <input type="checkbox"/> No	Year: _____	Results: _____
20.	<b>Allergies (please list) : Any specific reaction(s):</b>		
21.	<b>Currently taking medication:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
	<b>Name of medication(s):</b>		
	<b>Reason/Diagnosis:</b>		
22.	Disability: <input type="checkbox"/> Yes <input type="checkbox"/> No		
23.	Prosthesis: <input type="checkbox"/> Yes <input type="checkbox"/> No		
24.	Any medical reason why this child should NOT participate in Interscholastic Sports or related activities? Yes <input type="checkbox"/> No <input type="checkbox"/>		
25.	Has anyone in the athlete's family (grandparents, mother, father, brother, sister, aunt, uncle etc.) died suddenly before age 50? Yes <input type="checkbox"/> No <input type="checkbox"/>		
26.	Has the athlete ever stopped exercising because of dizziness or passing out during exercise? Yes <input type="checkbox"/> No <input type="checkbox"/>		
27.	Does the athlete have asthma (wheezing), hay fever or coughing spells after exercise? Yes <input type="checkbox"/> No <input type="checkbox"/>		
28.	Has the athlete ever had a broken bone, had to wear a cast, or had an injury to any joint? Yes <input type="checkbox"/> No <input type="checkbox"/>		
29.	Does the athlete have a history of concussion (getting knocked out)? Yes <input type="checkbox"/> No <input type="checkbox"/>		
30.	Has the athlete ever suffered a heat-related illness (heat stroke)? Yes <input type="checkbox"/> No <input type="checkbox"/>		

31.	Does the athlete have a chronic illness or see a doctor regularly for any health concerns? Yes <input type="checkbox"/> No <input type="checkbox"/>
32.	Does the athlete have only one of any paired organs (eyes, ears, kidneys, testicles, ovaries)? Yes <input type="checkbox"/> No <input type="checkbox"/>
33.	Has the athlete had an injury in the last year that caused the athlete to miss 3 or more consecutive days of practice or competition? Yes <input type="checkbox"/> No <input type="checkbox"/>
34.	Has the athlete had surgery or been hospitalized in the past year? Yes <input type="checkbox"/> No <input type="checkbox"/>
35.	Has the athlete missed more than 5 consecutive days of participation in usual activities because of illness, or has the athlete had a medical illness diagnosed that has not been resolved in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No
36.	Are you, the athlete, worried about any problem or condition at this time? <input type="checkbox"/> Yes <input type="checkbox"/> No
Please give details on any "Yes" answer(s) from the above health history.	

**NOTE:** Please notify the School Health Counselor or School Administrator if there are any changes in the health status of the student.

- Students must submit valid documentation to the school nurse showing completion of a **Physical Examination, Immunization, results of TB Skin Test and/or TB Clearance issued by DPHSS** and an **Emergency Information and Health Form.**
- Students who plan to participate in Interscholastic Activities/Athletics must submit a **completed Interscholastic Sport Association (ISA) Form.**

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Parent/Guardian (print) Signature Date

**PART II:  
PHYSICAL EXAMINATION – COMPLETED BY HEALTH CARE  
PRACTITIONER:**

**T-P-R-BP:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Height:** \_\_\_\_\_ **Vision:** Right 20/ \_\_\_\_\_ Corrected:  Yes  No **Hearing:** Right \_\_\_\_\_

**Weight:** \_\_\_\_\_ **BMI:** \_\_\_\_\_ Left 20/ \_\_\_\_\_ Contacts:  Yes  No Left \_\_\_\_\_

Complete Each Item Below	Normal		Describe Findings if Abnormal or Reason for not Examining
	Yes	No	
General appearance			
Skin			
Hair			
Nails			
Eyes: External (Pupil/Cornea)			
Optic Fundus			
Auditory Acuity			
Muscle Balance			
Ears: External			
Auditory Acuity			
Tympanic Membrane			
Nose			
Mouth			
Pharynx			
Larynx			
Speech			
Teeth/Gums			
Neck/Lymph/larynx			
Cardiovascular			
Respiratory			
Gastro Intestinal			
Genital-Urinary			
Muscular Skeletal			
Scoliosis Screening			
Neurological Impressions			
Nutritional Status			
Behavior during Examination			
<i>Other</i>			

**PART III  
LABORATORY TEST:**

<b>Hemoglobin:</b> _____	Date: _____	<b>Hematocrit:</b> _____	Date: _____
<i>Other Test</i>	<i>Date</i>	<i>Results</i>	
<i>Other Test</i>	<i>Date</i>	<i>Results</i>	

**Summary of Findings, Treatments and Recommendations:**

Diagnosis/Findings	Advice and Treatment Given	Recommendations and Follow-Up Plan



Approaches of Education Through Sports and Extending the Classroom to the Personal Field



**ISA**  
INTERSCHOLASTIC  
SPORTS ASSOCIATION

# Interscholastic Sports Association

Guam Department of Education



FORM 3 OF 5

Dear Parent or Guardian,

This **Media Release Form** is presented to you because your child’s photograph and video may be taken during athletic events for use in the local media to highlight the athletic programs of the Interscholastic Sports Association. Your permission is needed in order for his/her photograph and or videos to be published. Please complete the information below and have your child return this form prior to attending his/her first practice for school year 2024-2025.

*The waiver is **HIGHLY RECOMMENDED** for your child to obtain the full experience of competition. Schools and local media may use the footage to recognize your child for their hard work during the season. Keep in mind that participation in high school sports is voluntary – should the school team and ISA contract for a highly publicized event, your child may not be able to participate without the waiver form.*

Your assistance with this request is gratefully appreciated.

NAME OF SCHOOL: \_\_\_\_\_

## ISA ATHLETIC MEDIA RELEASE FORM

**Check one:**

I hereby GIVE permission for my child’s image to be used to promote league activities such as publications, media releases, announcements electronically or otherwise.

I hereby DO NOT GIVE my permission for my child’s image to be used.

Name of Student (Please Print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian (Please Print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please have your child return all forms to the Athletic Director.**

# FORM 4 OF 5

## GDOE INTERSCHOLASTIC SPORTS ASSOCIATION

### Concussion Information Sheet

A concussion is a brain injury and all brain injuries are serious. They are caused by a blow, a bump, or a jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, **all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly.** In other words, even a “ding” or a bump on the head can be serious. You can’t see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

#### Symptoms may include one or more of the following:

- |   |  |
|---|--|
| <ul style="list-style-type: none"><li><input type="checkbox"/> Headaches</li><li><input type="checkbox"/> “Pressure in head”</li><li><input type="checkbox"/> Nausea or vomiting</li><li><input type="checkbox"/> Neck pain</li><li><input type="checkbox"/> Balance problems or dizziness</li><li><input type="checkbox"/> Blurred, double, or fuzzy vision</li><li><input type="checkbox"/> Sensitivity to light or noise</li><li><input type="checkbox"/> Feeling sluggish or slowed down</li><li><input type="checkbox"/> Feeling foggy or groggy</li><li><input type="checkbox"/> Drowsiness</li><li><input type="checkbox"/> Change in sleep patterns</li></ul> | <ul style="list-style-type: none"><li><input type="checkbox"/> Amnesia</li><li><input type="checkbox"/> “Don’t feel right”</li><li><input type="checkbox"/> Fatigue or low energy</li><li><input type="checkbox"/> Sadness</li><li><input type="checkbox"/> Nervousness or anxiety</li><li><input type="checkbox"/> Irritability</li><li><input type="checkbox"/> More emotional</li><li><input type="checkbox"/> Confusion</li><li><input type="checkbox"/> Concentration or memory problems (forgetting game plays)</li><li><input type="checkbox"/> Repeating the same question/comment</li></ul> |
|---|--|

#### Signs observed by teammates, parents and coaches include:

- Appears dazed
- Vacant facial expression
- Confused about assignment
- Forgets plays
- Is unsure of game, score, or opponent
- Moves clumsily or displays incoordination
- Answers questions slowly
- Slurred speech
- Shows behavior or personality changes
- Can’t recall events prior to hit
- Can’t recall events after hit
- Seizures or convulsions
- Any change in typical behavior or personality
- Loses consciousness

# GDOE INTERSCHOLASTIC SPORTS ASSOCIATION

## Concussion Information Sheet

### **What can happen if my child keeps on playing with a concussion or returns to soon?**

Athletes with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one. This can lead to prolonged recovery, or even to severe brain swelling (second impact syndrome) with devastating and even fatal consequences. It is well known that adolescent or teenage athlete will often under report symptoms of injuries. And concussions are no different. As a result, education of administrators, coaches, parents and students is the key for student-athlete's safety.

### **If you think your child has suffered a concussion**

Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear, without medical clearance. Close observation of the athlete should continue for several hours. The GDOE ISA requires implementation of well-established return to play concussion guideline that has been recommended for several years:

“A student-athlete who is suspected of sustaining a concussion or head injury in a practice or game shall be removed from competition at that time and for the remainder of the day.”

**and**

“A student-athlete who has been removed may not return to play until the athlete is evaluated by a licensed health care provider trained in the evaluation and management of concussion and received written clearance to return to play from that healthcare provider”.

You should also inform your child's coach and/or Athletic Director if you think that your child may have a concussion Remember it's better to miss one game than miss the whole season. When in doubt, the athlete sits out.

For current and up-to-date information on concussions you can go to:

<http://www.cdc.gov/headsup/youthsports/index.html>

\_\_\_\_\_  
Student-athlete Name Printed

\_\_\_\_\_  
Student-athlete Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Legal Guardian Printed

\_\_\_\_\_  
Parent or Legal Guardian Signature

\_\_\_\_\_  
Date



# Interscholastic Sports Association

Guam Department of Education



## PARTICIPATION AGREEMENT

In consideration of the opportunity to have my child participate in Guam Department of Education Interscholastic Sports Association (ISA) activities, including School Year 2024-2025 school sports, I, the parent, guardian, or person having the care and custody of \_\_\_\_\_ (Participant), on behalf of myself, spouse, co-guardian, agents, heir, next of kin and the participant, hereby agree to the following:

**Waiver & Release:** I agree to release, indemnify, and hold harmless, the Guam Department of Education's Interscholastic Sports Association (herein referred to as the "ISA") and its respective member schools, coaches, development personnel, vendors and those contracted with the ISA to provide athletic facilities or services, employees, agents, members, directors, officers and representatives from any responsibility or liability for personal injury, including death, and damage to or loss of property, whether or not arising from the negligence of the ISA, that the participant may incur while traveling to or from, engaged in practice or competition, being coached, triaged by trainers, using or operating equipment or otherwise participating in the ISA activity. I hereby also acknowledge and waive the benefits of the provisions of 18 G.C.A. § 82602 (formerly § 1542 of the Civil Code of Guam) which reads as follows: A general release does not extend to claims which the creditor does not know or suspect to exist in his favor at the time of executing the release, which if known by him must have materially affected with the debtor.

**Covenant Not To Sue:** I warrant and agree that I will not make a claim against or sue the foregoing parties and their agents, contractors, and/or employers and forever release them and waive all actions, claims or demands that I may have or hereinafter have of whatsoever nature or kind including without limitation claims for personal injury or damage to personal property, loss of services, past or present, known or unknown, or any other claim arising out of participant's participation in ISA activities.

**Medical Care:** In addition, I understand that the ISA does not provide medical insurance coverage and that I, as a member and participant in ISA activities, should provide personal medical insurance. In the case of injury or medical emergency, the ISA has permission to seek, administer, or have administered whatever first aid or emergency medical care deemed necessary for participant's welfare, and it is understood that participant, and not the ISA, shall be responsible for any and all charges for such health care services regardless of whether

participant's medical insurance would cover such charges.

**Assumption of Risk:** Furthermore, I recognize that every ISA activity has certain degree of risk, and I knowingly and voluntarily assume the risk of any injuries, regardless of severity, including death, and all risk of damage to or loss of property which participant may incur, even if arising from the negligence of the ISA, while participant is participating in a ISA activity.

I, the undersigned, am competent to sign this release, and have read carefully, understand, and agree to all its terms.

Signed: \_\_\_\_\_

Relationship to Participant: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

Phone contact(s): \_\_\_\_\_

Email contact(s): \_\_\_\_\_