Gateway Christian School
ATHLETIC FEES
2023-2024

GRADE	SPORT	*FEE
7-8	JH FOOTBALL	$ 90.00
9-12	HS FOOTBALL	$140.00
6-8	JH GIRLS VOLLEYBALL	$ 50.00
9-12	HS GIRLS VOLLEYBALL	$ 70.00
8-12	HS BOYS & GIRLS CROSS-COUNTRY	$ 40.00
6-8	JH BOYS & GIRLS BASKETBALL	$ 50.00
9-12	HS BOYS & GIRLS BASKETBALL	$ 70.00
6-12	TRACK (BOYS & GIRLS)	$ 50.00
8-12	BASEBALL	$110.00

All students are required to have a physical before participating in practice or games. The physical forms are available in the elementary office.

GATEWAY CHRISTIAN SCHOOL

Warrior Athletic Department
1900 N. Sycamore ▪ P.O. Box 1642 ▪ Roswell, NM 88202
Phone (575) 622-9710
www.gatewaychristianschool.us

TRAVEL AND MEDICAL RELEASE

NAME OF CHILD_____AGE _____

HOME ADDRESS_____PHONE# _____

FATHER:_____PHONE#_____

WORK#_____CELL#_____EMERGENCY#_____

MOTHER:_____PHONE# _____

WORK#_____CELL#_____EMERGENCY# _____

NEIGHBOR/RELATIVE:_____PHONE# _____

FAMILY M.D./D.O./P.A/N.P.:_____PHONE# _____

FAMILY DENTIST:_____PHONE# _____

CHILD'S SOCIAL SECURITY # _

FAMILY'S PRIMARY HEALTH INSURANCE _____

POLICY#_____GROUP # _____

AUTHORIZATION FOR MEDICAL SERVICES

I/We request that I/we be contacted within a reasonable time in the event of illness or injury requiring medical service. In the event that we cannot be reached, I/we, parent/guardian(s) hereby designate the Athletic Director, Team Coach, Athletic Trainer, or his designee to act in my/our behalf to authorize in an emergency because of accident or illness and the situation calls for medical attention, we recognize and relinquish our responsibility to a practicing physician/doctor of osteopathy/physician's assistant/nurse practitioner and/or medical personnel acting in the best interest of my/our child/ward. I/we hereby assume financial responsibility for hospitalization, medical attention and surgery provided.

I/We grant permission for said student to participate in the planned activities of the travel, and to travel by car, bus, train, airplane, and other means of transportation as required. In case of illness or injury to said student during travel, I/we hereby consent to and agree to pay for such medical and dental costs incurred.

Travel Period: From June 1, 2023 to May 31, 2024

PARENT SIGNATURE_____**DATE** _____

Parents Comments: Please specify any special medical or other such instructions that need to be considered.

_____
_____
_____
_____
_____
_____
_____

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STUDENT ATHLETIC CONTRACT

Every sport has inherent risks, and regardless of the precautions taken, it is impossible to ensure the safety of the participant. Athletics requires a high level of fitness. It requires quick bursts of speed, long period of running, and jumping. It also can involve contact with other participants, balls, the floor, and other objects in the gymnasium or the field. It is a reasonably safe sport as long as certain guidelines are followed.

Some hazards are the possibility of being hit by the ball, colliding with other players, or with objects in the gymnasium or on the field during a game or practice. A variety of injuries may occur including, but not limited to muscle strain, sprains, fractures, contusions, abrasions, and dehydration. Serious and disabling injuries and even death could result from participation of volleyball. It is not possible to list each specific risk.

To help reduce the risk of injury to yourself and other participants, the following safety rules need to be followed during practice and games (1) Wear all of the equipment given to you by the coaches and/or trainers or doctors (2) obey the rules of the sport, (3) report any discovered defects in the game or practice area or in the equipment immediately.

I agree to follow the preceding safety rules as well as others given to me by the coach. I also agree to report any injury to the coaching staff on the day that it occurs.

I certify that (1) I am physically fit to participate in athletics, (2) I understand that I am free to discontinue activity at any time I feel undue discomfort or stress, and (3) ***on the following lines is a complete list of any health-related conditions that might affect my ability to participate in athletics.***

_____
_____
_____
_____
_____

I have read and agree to follow the guidelines set forth in the **Athletic Handbook**. I understand the provisions, fees, guidelines, rules and consequences of breaking said rules.

I/we agree to do our best to exemplify Christ at all times at school, games and at home.

_____ _____
Student's Signature Parents' Signature (s)

_____ _____
Date Date

Please initial each sport you agree to participate in:

_____BASEBALL _____FOOTBALL

_____BASKETBALL _____TRACK AND FIELD

_____CHEERLEADING _____VOLLEYBALL

_____CROSS-COUNTRY

MEDICAL EXAMINATION FOR PARTICIPATION IN INTERSCHOLASTIC ATHLETICS

(Cover sheet)

New Mexico Activities Association
6600 Palomas NE
Albuquerque, NM 87109
www.nmact.org

NOTE: The NMAA does not need a copy of this form. Please return to your school's athletic department.

Medical History – Parent/Guardian please fill out prior to examination.

Student Athlete Name *(Last, First, M.I.):*					
Home Address:				Grade:	
Street	*City*	*State*	*Zip*		
DOB:				AGE:	
Name of Parent/Guardian					
Home Address:				Phone:	Work:
Street	*City*	*State*	*Zip*	Cell:	
Emergency Contact				Phone:	Work:
Name		*Relationship*		Cell:	
Address:					
Street	*City*	*State*	*Zip*		

SPORT/ACTIVITY STUDENT WILL PARTICIPATE IN (CHECK ALL THAT APPLY)

Sports/Activities

☐ Baseball	☐ Football	☐ Cheer/Drill	☐ Wrestling	☐ Bowling
☐Track/Field	☐ Tennis	☐ Volleyball	☐ Golf	☐ Other_____
☐ Cross country	☐ Soccer	☐ Softball	☐ Basketball	

Please answer all health history questions on the following page PRIOR to your visit to the doctor. Please fill in the student athlete's personal information (name, gender and birth date) on each page of the form and return the entire packet to the school's athletic department.

Concussion Management

A concussion is a disturbance in the function of the brain that can be caused by a blow to the body or head and may occur in any sport or activity. Effects of a concussion may include a variety of symptoms (headache, nausea, dizziness, memory loss, balance problem) with or without a loss of consciousness. I/we understand there is a concussion management protocol established that includes care and return to play criteria.

_____ _____
Student-Athlete Signature Date

_____ _____
Parent or Court Appointed Legal Guardian Signature Date

ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION FORM
Part A: Health History Form
Student Athlete Name_____Gender_____DOB _____

1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	Yes	☐	No	23. Has a doctor ever told you that you have asthma or allergies?	☐		☐	No
2. Do you have an ongoing medical condition (like diabetes or asthma)?	☐	Yes	☐	No	24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	Yes	☐	No
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	Yes	☐	No	25. Is there anyone in your family with asthma?	☐	Yes	☐	No
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	Yes	☐	No	26. Have you ever used an inhaler or taken asthma medicine?	☐	Yes	☐	No
5. Have you ever become dizzy or passed out **DURING or AFTER** exercise?	☐	Yes	☐	No	27. Were you born without or are you missing a kidney, an eye or testicle, or any other organ?	☐	Yes	☐	No
6. Have you ever had discomfort, pain, or pressure in your chest during or after exercise?	☐	Yes	☐	No	28. Have you had a severe viral infection such as infectious mononucleosis (mono) or myocarditis in the last month?	☐	Yes	☐	No
7. Do you get more tired than your friends do during exercise?	☐	Yes	☐	No	29. Do you have any rashes, pressure sores or other skin problems?	☐	Yes	☐	No
9. Has a doctor ever told you that you have: ☐High Blood Pressure ☐Heart Murmur ☐Heart Infection ☐High Cholesterol (Check all that apply)	☐	Yes	☐	No	30. Have you had a herpes infection?	☐	Yes	☐	No
					31. Have you had a head injury or concussion?	☐	Yes	☐	No
					32. Have you been hit in the head and been confused or lost your memory?	☐	Yes	☐	No
10. Has a doctor ever ordered a test for your heart?(for example ECG, echocardiogram)	☐	Yes	☐	No	33. Have you ever had a seizure?	☐	Yes	☐	No
11. Has anyone in your family ever died for no apparent reason?	☐	Yes	☐	No	34. Do you have headaches with exercise?	☐	Yes	☐	No
12. Does any one in your family have a heart problem?	☐	Yes	☐	No	35. Have you ever had numbness or tingling or weakness in your arms, or legs?	☐	Yes	☐	No
13. Has a family member or relative died of heart problems or sudden death before the age of 50?	☐	Yes	☐	No	36. Have you ever been unable to move your arms or legs after being hit or fallen?	☐	Yes	☐	No
14. Have any of your relatives ever had any one of the following conditions? Hypertrophic cardiomyopathy, dilated cardiomyopathy, Marfan's syndrome or Long QT Syndrome or a significant heart arrhythmia?	☐	Yes	☐	No	37. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	Yes	☐	No
					38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	Yes	☐	No
15. Have you ever had racing of your heart or skipped heartbeats?	☐	Yes	☐	No	39. Have you had any problems with your eyes or vision?	☐	Yes	☐	No
					40. Do you wear glasses or contact lenses?	☐	Yes	☐	No
16. Have you ever spent the night in a hospital?	☐	Yes	☐	No	41. Do you wear protective eyewear such as goggles or a face shield?	☐	Yes	☐	No
17. Have you ever had surgery?	☐	Yes	☐	No	42. Are you unhappy with your weight?	☐	Yes	☐	No
					43. Are you trying to gain or lose weight?	☐	Yes	☐	No
					44. Has anyone recommended you change your weight or eating habits?	☐	Yes	☐	No
					45. Do you limit or carefully control what you eat?	☐	Yes	☐	No
					46. Do you have concerns that you would like to discuss with the doctor/health care provider?	☐	Yes	☐	No

18. Have you ever had an injury, like a sprain, muscle or ligament tear or tendonitis that caused you to miss a practice or game? ☐ Yes ☐ No If yes circle affected area below:

19. Have you had any broken or fractured bones or dislocated joints? ☐ Yes ☐ No If yes circle affected area below:

20. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast or crutches? ☐ Yes ☐ No If yes circle affected are below:

Head	Neck	Shoulder	Upper arm	Elbow	Calf or shin	Hand	Chest
Upper back	Lower Back	Forearm	Thigh	Knee	Hip	Ankle	Foot Toes

21. Have you ever had a stress fracture?	☐	Yes	☐	No
22. Have you ever been told that you have or have had an x-ray for atlantoaxial (neck) instability?	☐	Yes	☐	No
23. Do you regularly use a brace or assistive device?	☐	Yes	☐	No

FEMALES ONLY:
47. Have you ever had a menstrual period? ☐Yes ☐No
48. How old were you when you had your first menstrual period? _____
49. How many periods have you had in the last 12 months? _____

Explain "Yes" answers here (*use the back of the form if necessary):*

_____
_____
_____
_____
_____
_____

ATHLETIC PRE-PARTICIPATION PHYSICAL EVALUATION FORM
Part B: Physical Examination
Athlete Name_____ Gender____ DOB_____

TO BE COMPLETED BY THE EXAMINING PHYSICIAN OR PROVIDER -PLEASE COMPLETE BOTH PAGES

Student Athlete Name *(Last, First, M.I.):* **DOB:** **Height_____ Weight:_____**

BMI %ile____ **Pulse:_____** *(Per CDC %ile charts)*

Blood Pressure:_____/____ *(Recheck if elevated)* **_____/____ ____/_____**

Blood Pressure %ile_____ *(per NIH guidelines)*

Vision: R20/___L20/____Corrected: Y / N Pupils : Equal_____Unequal_____

MEDICAL	**Normal** (*circle one*)		**Abnormal Findings/Comments**
Appearance	YES	NO	
Eyes/Ears/Nose/Throat	YES	NO	
Hearing	YES	NO	
Lymph nodes	YES	NO	
Heart (*auscultation should be done supine and standing- abnormal findings require referral for further evaluation)*	YES	NO	
Murmurs	YES	NO	
Pulses	YES	NO	
Lungs: Auscultation	YES	NO	
Abdomen: Assessment (*incl. liver, spleen)*	YES	NO	
Genitourinary (*males only)*	YES	NO	
Skin	YES	NO	
MUSCULOSKELETAL			
Neck	YES	NO	
Back	YES	NO	
Shoulder/Arm	YES	NO	
Elbow/Forearm	YES	NO	
Wrist/Hand/Fingers	YES	NO	
Hip/Thigh	YES	NO	
Knee	YES	NO	
Leg/Ankle	YES	NO	
Foot/Toes	YES	NO	

NOTES:_____

_____

Does Athlete wear contacts? ☐ Yes ☐ No
Does Athlete require eye protection while playing? ☐ Yes ☐ No

Student MAY participate in the following types of sports (CHECK ALL THAT APPLY):
☐ **ALL FORMS OF SPORTS** ☐ CONTACT/COLLISION ☐ NON-CONTACT/STRENUOUS
☐ LIMITED CONTACT ☐ NON-CONTACT/NON-STRENUOUS
☐ STUDENT CLEARED FOR PARTICIPATION
☐ STUDENT CLEARED FOR PARTICIPATION PENDING _____
☐ STUDENT NOT CLEARED FOR PARTICIPATION
Name of Physician/Provider (print/type)_____Date_____

Signature of Physician /Provider _____

Student's Primary Physician/Provider (for follow up, if necessary):_____

CLEARANCE FORM

Athlete Name:_____ **Gender**_____ **DOB** _____

SAMPLES OF CLASSIFICATION OF SPORTS BY CONTACT			
Contact/Collision	**Limited Contact**	**Non-Contact**	
		Strenuous	**Non-strenuous**
Field Hockey	Baseball	Discus	Bowling
Football	Basketball	Javelin	Golf
Ice Hockey	Cheerleading	Shot put	
Lacrosse	Diving	Rowing	
Soccer	Fencing	Running/Cross Country	
Wrestling	Field	Strength Training	
	High Jump	Swimming	
	Pole vault	Tennis	
	Gymnastics	Track	
	Skiing		
	Softball		
	Volleyball		

Student MAY participate in the following types of sports: (CHECK ALL THAT APPLY)

☐ **STUDENT CLEARED FOR ALL FORMS OF SPORTS**

☐ CONTACT/COLLISION ☐ NON-CONTACT/STRENUOUS ☐ LIMITED CONTACT ☐ NON-CONTACT/NON-STRENUOUS

☐ **STUDENT CLEARED FOR PARTICIPATION**

☐ **STUDENT CLEARED FOR PARTICIPATION PENDING:** _____

☐ **STUDENT NOT CLEARED FOR PARTICIPATION**

STUDENT ATHLETE EMERGENCY INFORMATION

ALLERGIES_____ **HISTORY OF ANAPHYLAXIS?** ☐ Yes ☐ No

IMMUNIZATIONS ☐Up to date Last Tetanus Immunization _____

Significant Medical History Information (*Please Include any history of asthma, hypertension, previous head injury, unequal pupil size etc.)*

Student's Primary Physician/Provider *(For follow up, if necessary*):_____

Current Medical Conditions:

Current Medications(*if on asthma medication please indicate if needed prior to sports*)**:**

Does Athlete wear contacts? ☐ Yes ☐ No **Does Athlete require eye protection while playing? ☐ Yes ☐ No**

Providers Name		**__MD___DO____NP___PA___DC**	**Phone:**
Address:			
Street	*City*	*State* *Zip*	
Signature of Provider			**Date:**