



COVID-19 Procedures Marion County Football

Summer Workouts Starting June 1st

- *PLAYERS AND COACHES WASH/SANITIZE HANDS WHEN ENTERING AND LEAVING WORKOUTS
 - *NO SUPERSETS OR CIRCUITS, ONE PIECE OF EQUIPMENT AT A TIME
 - *LOCKER ROOMS AND OTHER GATHERING AREAS ARE CLOSED
 - *NO COMMUNAL WATER STATIONS OR DRINK AREAS SUCH AS FOUNTAINS, COOLERS, HOSES, PROTEIN MIXES ETC...
 - *TEMPERATURE CHECK EACH PLAYER WHEN THEY COME IN, 100.4 OR ABOVE SEND PLAYER HOME IMMEDIATELY
 - *IF PLAYER IS SICK HAS DIAHREA OR HAS BEEN AROUND SOMEONE WITH COVID-19 SYMPTOMS-STAY HOME
 - *ADULT/COACH CLEAN STATIONS BETWEEN EACH GROUP, USE CLOROX WIPES OR MIXTURE OF BLEACH AND WATER
 - *HAVE DOORS AND WINDOWS OPEN FOR VENTILATION
 - *ADJUST EQUIPMENT LAYOUT IF IN CLOSE PROXIMITY AND MARK OFF SOCIAL DISTANCING AREAS
 - *NO MORE THAN 10 PLAYERS IN A GROUP
 - *MASK ARE OPTIONAL
 - *RE-EVALUATION OF WORKOUT WILL BE AFTER DURING DEAD PERIOD (DEAD PERIOD (JUNE 20TH THRU JULY 5TH))
 - *WORKOUTS BEGIN JUNE 1ST MONDAY ,TUESDAY,WEDNESDAY AND THURSDAY 6PM TILL 8PM
- PLAYER DO NOT ARRIVE UNTILL 15 MINUTES BEFORE WORKOUT, ENTER AT PASS GATE BY THE FIELD HOUSE, YOU MUST HAVE TEMPERATURE TAKEN.
- DO NOT SIT TOGETGER STAY AT LEAST 6 FOOT APART,AND WHEN WE FINISH GO HOME,DON'T HANG OUT IN PARKING LOTS

PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam _____
Name _____ Date of birth _____
Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS		Yes	No	MEDICAL QUESTIONS		Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?				26. Do you cough, wheeze, or have difficulty breathing during or after exercise?			
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____				27. Have you ever used an inhaler or taken asthma medicine?			
3. Have you ever spent the night in the hospital?				28. Is there anyone in your family who has asthma?			
4. Have you ever had surgery?				29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?			
HEART HEALTH QUESTIONS ABOUT YOU		Yes	No	30. Do you have groin pain or a painful bulge or hernia in the groin area?			
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?				31. Have you had infectious mononucleosis (mono) within the last month?			
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?				32. Do you have any rashes, pressure sores, or other skin problems?			
7. Does your heart ever race or skip beats (irregular beats) during exercise?				33. Have you had a herpes or MRSA skin infection?			
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____				34. Have you ever had a head injury or concussion?			
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)				35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?			
10. Do you get lightheaded or feel more short of breath than expected during exercise?				36. Do you have a history of seizure disorder?			
11. Have you ever had an unexplained seizure?				37. Do you have headaches with exercise?			
12. Do you get more tired or short of breath more quickly than your friends during exercise?				38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?			
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		Yes	No	39. Have you ever been unable to move your arms or legs after being hit or falling?			
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?				40. Have you ever become ill while exercising in the heat?			
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?				41. Do you get frequent muscle cramps when exercising?			
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?				42. Do you or someone in your family have sickle cell trait or disease?			
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?				43. Have you had any problems with your eyes or vision?			
BONE AND JOINT QUESTIONS		Yes	No	44. Have you had any eye injuries?			
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?				45. Do you wear glasses or contact lenses?			
18. Have you ever had any broken or fractured bones or dislocated joints?				46. Do you wear protective eyewear, such as goggles or a face shield?			
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?				47. Do you worry about your weight?			
20. Have you ever had a stress fracture?				48. Are you trying to or has anyone recommended that you gain or lose weight?			
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)				49. Are you on a special diet or do you avoid certain types of foods?			
22. Do you regularly use a brace, orthotics, or other assistive device?				50. Have you ever had an eating disorder?			
23. Do you have a bone, muscle, or joint injury that bothers you?				51. Do you have any concerns that you would like to discuss with a doctor?			
24. Do any of your joints become painful, swollen, feel warm, or look red?				FEMALES ONLY			
25. Do you have any history of juvenile arthritis or connective tissue disease?				52. Have you ever had a menstrual period?			
				53. How old were you when you had your first menstrual period?			
				54. How many periods have you had in the last 12 months?			

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

PREPARTICIPATION PHYSICAL EVALUATION **THE ATHLETE WITH SPECIAL NEEDS:** **SUPPLEMENTAL HISTORY FORM**

This document is only necessary when the individual has a documented special need.

Date of Exam _____
 Name _____ Date of birth _____
 Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
6. Do you regularly use a brace, assistive device, or prosthetic?	Yes	No
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

- Consider additional questions on more sensitive issues
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance supplement?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (questions 5-14).

EXAMINATION			
Height	Weight	<input type="checkbox"/> Male <input type="checkbox"/> Female	
BP	/	(/)	Pulse
Vision R 20/		L 20/	
Corrected <input type="checkbox"/> Y <input type="checkbox"/> N			
MEDICAL		NORMAL	ABNORMAL FINDINGS
Appearance <ul style="list-style-type: none"> Martian stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) 			
Eyes/ears/nose/throat <ul style="list-style-type: none"> Pupils equal Hearing 			
Lymph nodes			
Heart* <ul style="list-style-type: none"> Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (PMI) 			
Pulses <ul style="list-style-type: none"> Simultaneous femoral and radial pulses 			
Lungs			
Abdomen			
Genitourinary (males only)*			
Skin <ul style="list-style-type: none"> HSV, lesions suggestive of MRSA, tinea corporis 			
Neurologic*			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
Functional <ul style="list-style-type: none"> Duck-walk, single leg hop 			

*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

*Consider GU exam if in private setting. Having third party present is recommended.

*Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

☐ Not cleared

☐ Pending further evaluation

☐ For any sports

☐ For certain sports _____

Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

**PREPARTICIPATION PHYSICAL EVALUATION
CLEARANCE FORM**

This form is for summary use in lieu of the physical exam form and health history form and may be used when HIPAA concerns are present.

Name _____ Sex ☐ M ☐ F Age _____ Date of birth _____

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

☐ Not cleared

☐ Pending further evaluation

☐ For any sports

☐ For certain sports _____

Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

EMERGENCY INFORMATION

Allergies _____

Other information _____

CONSENT FOR ATHLETIC PARTICIPATION & MEDICAL CARE

*Entire Page Completed By Patient

Athlete Information

Last Name _____ First Name _____ MI _____

Sex: ☐ Male ☐ Female Grade _____ Age _____ DOB ____/____/____

Allergies _____

Medications _____

Insurance _____ Policy Number _____

Group Number _____ Insurance Phone Number _____

Emergency Contact Information

Home Address _____ (City) _____ (Zip) _____

Home Phone _____ Mother's Cell _____ Father's Cell _____

Mother's Name _____ Work Phone _____

Father's Name _____ Work Phone _____

Another Person to Contact _____

Phone Number _____ Relationship _____

Legal/Parent Consent

I/We hereby give consent for (athlete's name) _____ to represent (name of school) _____ in athletics realizing that such activity involves potential for injury. I/We acknowledge that even with the best coaching, the most advanced equipment, and strict observation of the rules, injuries are still possible. ***On rare occasions these injuries are severe and result in disability, paralysis, and even death. I/We further grant permission to the school and TSSAA, its physicians, athletic trainers, and/or EMT to render aid, treatment, medical, or surgical care deemed reasonably necessary to the health and well being of the student athlete named above during or resulting from participation in athletics.*** By the execution of this consent, the student athlete named above and his/her parent/guardian(s) do hereby consent to screening, examination, and testing of the student athlete during the course of the pre-participation examination by those performing the evaluation, and to the taking of medical history information and the recording of that history and the findings and comments pertaining to the student athlete on the forms attached hereto by those practitioners performing the examination. As parent or legal Guardian, ***I/We remain fully responsible for any legal responsibility which may result from any personal actions taken by the above named student athlete.***

Signature of Athlete

Signature of Parent/Guardian

Date

Student-athlete & Parent/Legal Guardian Concussion Statement

Must be signed and returned to school or community youth athletic activity prior to participation in practice or play.

Student-Athlete Name: _____

Parent/Legal Guardian Name(s): _____

After reading the information sheet, I am aware of the following information:

Student-Athlete initials		Parent/Legal Guardian initials
	A concussion is a brain injury which should be reported to my parents, my coach(es) or a medical professional if one is available.	
	A concussion cannot be "seen." Some symptoms might be present right away. Other symptoms can show up hours or days after an injury.	
	I will tell my parents, my coach and/or a medical professional about my injuries and illnesses.	N/A
	I will not return to play in a game or practice if a hit to my head or body causes any concussion-related symptoms.	N/A
	I will/my child will need written permission from a <i>health care provider*</i> to return to play or practice after a concussion.	
	Most concussions take days or weeks to get better. A more serious concussion can last for months or longer.	
	After a bump, blow or jolt to the head or body an athlete should receive immediate medical attention if there are any danger signs such as loss of consciousness, repeated vomiting or a headache that gets worse.	
	After a concussion, the brain needs time to heal. I understand that I am/my child is much more likely to have another concussion or more serious brain injury if return to play or practice occurs before the concussion symptoms go away.	
	Sometimes repeat concussion can cause serious and long-lasting problems and even death.	
	I have read the concussion symptoms on the Concussion Information Sheet.	

** Health care provider means a Tennessee licensed medical doctor, osteopathic physician or a clinical neuropsychologist with concussion training*

Signature of Student-Athlete

Date

Signature of Parent/Legal guardian

Date

Athlete/Parent/Guardian Sudden Cardiac Arrest Symptoms and Warning Signs Information Sheet and Acknowledgement of Receipt and Review Form

What is sudden cardiac arrest?

Sudden cardiac arrest (SCA) is when the heart stops beating, suddenly and unexpectedly. When this happens, blood stops flowing to the brain and other vital organs. SCA doesn't just happen to adults; it takes the lives of students, too. However, the causes of sudden cardiac arrest in students and adults can be different. A youth athlete's SCA will likely result from an inherited condition, while an adult's SCA may be caused by either inherited or lifestyle issues. SCA is NOT a heart attack. A heart attack may cause SCA, but they are not the same. A heart attack is caused by a blockage that stops the flow of blood to the heart. SCA is a malfunction in the heart's electrical system, causing the heart to suddenly stop beating.

How common is sudden cardiac arrest in the United States?

SCA is the #1 cause of death for adults in this country. There are about 300,000 cardiac arrests outside hospitals each year. About 2,000 patients under 25 die of SCA each year. It is the #1 cause of death for student athletes.

Are there warning signs?

Although SCA happens unexpectedly, some people may have signs or symptoms, such as:

- fainting or seizures during exercise;
- unexplained shortness of breath;
- dizziness;
- extreme fatigue;
- chest pains; or
- racing heart.

These symptoms can be unclear in athletes, since people often confuse these warning signs with physical exhaustion. SCA can be prevented if the underlying causes can be diagnosed and treated.

What are the risks of practicing or playing after experiencing these symptoms?

There are risks associated with continuing to practice or play after experiencing these symptoms. When the heart stops, so does the blood that flows to the brain and other vital organs. Death or permanent brain damage can occur in just a few minutes. Most people who experience SCA die from it.

Public Chapter 325 – the Sudden Cardiac Arrest Prevention Act

The act is intended to keep youth athletes safe while practicing or playing. The requirements of the act are:

- All youth athletes and their parents or guardians must read and sign this form. It must be returned to the school before participation in any athletic activity. A new form must be signed and returned each school year.

- The immediate removal of any youth athlete who passes out or faints while participating in an athletic activity, or who exhibits any of the following symptoms:
 - (i) Unexplained shortness of breath;
 - (ii) Chest pains;
 - (iii) Dizziness
 - (iv) Racing heart rate; or
 - (v) Extreme fatigue; and
- Establish as policy that a youth athlete who has been removed from play shall not return to the practice or competition during which the youth athlete experienced symptoms consistent with sudden cardiac arrest
- Before returning to practice or play in an athletic activity, the athlete must be evaluated by a Tennessee licensed medical doctor or an osteopathic physician. Clearance to full or graduated return to practice or play must be in writing.

I have reviewed and understand the symptoms and warning signs of SCA.

Signature of Student-Athlete

Print Student-Athlete's Name Date

Signature of Parent/Guardian

Print Parent/Guardian's Name Date

Marion County High School Internet Usage

Permission Form

Student Name _____ Date _____

Dear Parents or Guardian:

With your permission your young adult will be able to access the Internet at school as part of their class instruction. Below are the rules for school Internet use. Please read before you grant permission.

Guidelines for Internet Usage

1. All students must have assigned permission form from their parents or Guardians that authorizes them to access to the Internet.
2. Respect for the equipment of the school and its network is a condition for use of computers.
3. Students are to notify the Teacher/Librarian immediately of any disturbing material they may encounter on the web or in e-mail.
4. Students are not to give out personal information like telephone number, full name, address, etc. on the Internet. Unless it's for College admissions or Act, and FASFA.
5. Students are to never give anyone their password to any of their accounts or allow another student to use their account to access the Internet or school network.
6. Students must have permission to download any program from the Internet.
7. All flash drives must be scanned for viruses by Computer Tech.

Violation of these rules may result in forfeiture of permission to use the Internet and School Network and or appropriate disciplinary actions. Please sign below if granting permission and have entire form returned. Do not tear off the bottom.

Permission

I _____ give my permission for _____ to access the Internet and publish class –related information on it in accordance with above guidelines.

Date _____

I _____ have also read the above and will honor the guidelines.

Students signature _____

Marion County High School Consent Form Media Release

Please ensure one box is checked for Part 1 and one box is checked for Part 2 of this form.

Part 1— Events

I, _____, hereby agree and give my permission for the
(Name of parent/guardian if student is a minor, under the age of 18.
Name of student if an adult, 18 years of age or older.)

Marion County School Board and/or partners to record, film, photograph, audiotape or videotape my/my child's name, image, student work, and performance and to display, publish or distribute these Works for the purpose of publishing, posting on the Marion County website, posting in schools, posting on social media sites and/or for broadcasting on television or radio as determined by the Marion County Schools.

I hereby waive any right to approve the use of this media now or in the future, whether the use is known to me or unknown, and I waive any right to any royalties related to the use of the media.

I understand that the media may appear in electronic form on the internet or in other publications outside of the Marion County Schools control. I agree that I will not hold the Marion County Schools responsible for any harm that may arise from such unauthorized reproduction.

- ☐ Please mark this box if you **AGREE** that your child may participate in recorded /school events and Marion County Schools hosted events as described above. (See Part 2 below)
- ☐ Please mark this box if you **DO NOT WISH** your child to participate in recorded Marion County Schools events and Marion County Schools hosted events.

Part 2 – Media Specific

I also understand that external media organizations may attend school events. I give permission for my/my child's name, image, student work, and performance to be photographed, filmed, audio-taped or videotaped for the purpose of being published and/or broadcast on-line, on television or radio.

- ☐ Please mark this box if you **AGREE** that your child may participate in media events that may be published or broadcast by organizations external to the Marion County School Board.
- ☐ Please mark this box if you **DO NOT WISH** your child to be photographed, filmed, audio-taped or videotaped at media events.

I have read this Student Media Release Consent Form and I fully understand the contents and meaning of this release. I understand that I am free to contact the Principal with any questions regarding this release.

Student's Name: _____ Grade: _____

School: _____

Student's Signature (If 18 years of age or older) _____

Parent's/Guardian's Name: _____

Parent's/Guardian's Signature (If student is a minor – under the age of 18): _____ Date _____

Marion County High School Parent/Student Athletic Contract

Parent/Coach Relationships

Both parenting and coaching are extremely challenging responsibilities. By understanding each role in the relationship, we can accept the actions of others and create an environment of success.

Communication that you should expect from your child's coach:

- Expectations and goals
- Locations and times of practices/games
- Team requirements
- Athletic contract outlining procedures and guidelines

Communication that coaches should expect from parents:

- Concerns expressed directly to the coach
- Advance notification of any scheduling conflicts
- Notifications of illness or injury as soon as possible

Procedures to follow if you have a concern to discuss with a coach:

- Call the coach to arrange an appointment.
- Please do not attempt to discuss an issue with a coach before or immediately after a contest or practice. Since this can be an emotional time for all concerned, meetings of this nature usually result in embarrassing, non-productive events.

What can a parent do if meeting with the coach did not provide a satisfactory resolution?

- Call the school to arrange an appointment with the athletic director or administration.
- Treat all involved with respect by not involving other parents, social media, etc. until the matter can first be discussed with the aforementioned person(s).

Student Discrimination/Harassment and Bullying/Intimidation/Cyber Bullying Policy

Not Allowed

- Acts of bullying, cyber-bullying, discrimination, harassment, hazing or any other victimization of students, based on any actual or perceived traits or characteristics.

The policy applies to both employees and students as well as their behaviors.

The actions are not allowed on school property, at school sponsored events, or outside of school if they are directed specifically at a student or create a disruption to the learning environment.

Definitions

Bullying/Intimidation/Harassment

- Physically harming a student or damaging a student's property
- Causing a student to fear physical harm or damage to their property
- Causing emotional distress to a student
- Creating a hostile educational environment

Cyber-bullying

- Bullying that occurs on an electronic device

Hazing

- An act by one student or group of students toward another student that endangers the mental or physical health of the student(s)

Student Code of Conduct

Category 2 or 3 Offense

- Category 2 Offense
 - o May result in suspension or referral outside of the school. First Time Category 2 Offense – 5 days suspension. Second Time Category 2 Offense – 10 days suspension. Third Time Category 2 Offense – Referral to Board of Education for Expulsion.
- Category 3 Offense
 - o Immediate referral to Board of Education for Expulsion

Reporting

- Schools will have a system in place for students to report bullying. Once a report is made by the victim or any other individual, the school will conduct an investigation. Actions will be taken by the school based on the investigation. Results of the investigation and actions will be reported to the Director of Schools.

General Information

1. Athletic contracts will be given to all students and parents and must be signed before students will be allowed to participate. Marion County High School (MCHS) is a member of the Tennessee Secondary Schools Athletic Association (TSSAA) and is under its constitution and bylaws. The coaches will make all decisions about team members and playing time. This is school ball. This in no way guarantees your child any playing time at all. Issues are not to be discussed in front of the students before or after a practice or a game.
2. Admission for all athletic events will be set by the District/Region or by the individual sport.
3. Schedules are set months in advance but are subject to change due to weather or other reasons.
4. The TSSAA enforces a two-week Dead Period during the summer. This Dead Period is the last week of June and the first week of July. It is highly recommended that families take their summer vacation during this time to avoid conflicts with the various summer sports activities.
5. The TSSAA requires that physicals must be completed by a licensed medical professional after April 15th in order to be eligible for the upcoming school year. Forms are available at school or on the school website.
6. At no times are parents to be on the practice or playing field unless you have received prior approval from a member of the MCHS coaching staff.
7. Practice will be as designated by the coach. Each player is responsible for telling parents what time practice is over. Please do not call the office, as the secretaries do not always have practice schedules. If a student misses two **CONSECUTIVE** practices without notifying the coach, he/she will automatically be dismissed from the team.
8. Parents must provide transportation to/from practice as well as games. Your child will need a note giving permission to ride with other parents, if you are not going to the game. The note needs to be turned into the coach the morning of the event.

Student Responsibilities

1. Academics - All sports teams at MCHS will follow the TSSAA standard for adequate academic progress. Coaches may require players to attend tutoring sessions if the student is in danger of failing classes.
2. Any player that receives disciplinary action in school may be reprimanded by the coach for not following team leadership roles. Players' behavior must be exemplary. Suspension from school may result in dismissal from the team. The coach and school administration will evaluate each case individually.
3. Social Media Policy – At all times, you represent MCHS. Be aware of what you post online. Do not post anything (words or pictures) that you wouldn't want friends, enemies, parents, teachers, or a future employer to see. Always speak of MCHS, its faculty, staff, and students in a positive way. Any postings deemed inappropriate by the head coach and/or administration may result in disciplinary action up to and including immediate dismissal from the team.
4. If a player is to miss practice for any reason, he/she must inform the coaching staff prior to the practice unless an emergency arises and there is not time to tell the staff. If a student misses two **CONSECUTIVE** practices without notifying the coach, he/she will automatically be dismissed from the team.
5. Any dissention between players will not be tolerated. If this happens, the players may be asked to turn in their uniforms. Players need to learn to be teammates and support one another.
6. Any student/athlete that is injured during practice/games should immediately notify his/her coach. MCHS utilizes an athletic trainer who is responsible for the medical care of our student athletes. The trainer will evaluate the student/athlete and recommend medical care needed. The athletic trainer can also schedule appointments with orthopedic or physical therapy professionals as needed.

SIGNATURE PAGE

By signing this form you are stating that you understand and agree to abide by all the above rules. This information must be completed for each sport and must be completed each year. Students will not be allowed to play until form is signed and returned.

Parent's Signature _____
Date _____

Athlete's Signature _____
Date _____

FOOTBALL EMERGENCY TREATMENT AUTHORIZATION CARD

School: Marion County High School

School Year: 2020-2021

Grade: _____

_____, hereby approve emergency treatment by the hospital and/or physician for
PARENT/GUARDIAN

ATHLETE'S NAME: _____

I will assume financial responsibility for the bills incurred if no insurance is listed below.

Primary Insurance Company

Policy Number

Insurance Company Address

**"UNDER PENALTIES OF PERJURY, I DECLARE THAT I HAVE READ THE FOREGOING
(DOCUMENT) AND THAT THE FACTS STATED IN IT ARE TRUE."**

Parent/Guardian Signature
Give full Home Address on line below:

Telephone No. (Cell): _____

Telephone No. (Work): _____

Street Address

City

State

Zip Code

Athlete's Date of Birth: _____ Date of Last Tetanus Shot: _____

My child is allergic to the following medications or has the following allergies:

Please list below any serious injuries or illnesses your child has had:

Alternate family member/friend to contact in case of emergency:

Telephone Number: _____ Name: _____

Family physician name and telephone number: _____

State special instructions to follow in case of emergency: _____