



BERNALILLO PUBLIC SCHOOLS

ATHLETIC DEPARTMENT

Terry Darnell Athletic Director
250 Isidro Sanchez Rd. Bernalillo NM 87004
(505) 404-5144 Fax (505)867-7826

PICKUP AND DROP OFF PROCEDURES FOR **AFTER SCHOOL PRACTICES AND ATHLETIC CONTESTS** **2016/2017 SCHOOL YEAR**

The following procedures will be implemented immediately for the athletic transportation to and from practices and events. The attached map outlines the ONLY drop-off and pickup points that will be used.

PICKING UP ATHLETES

- Athletes will be picked up at designated areas only! It is the responsibility of the parent to provide transportation to and from designated bus stop areas.
- Athletes must be at the bus pickup sight at the designated time. Once all athletes are loaded onto the bus at the designated sight, the bus driver will then leave to the next designated sight on the route.
- If an athlete does not make the designated area by the time the bus leaves, the athlete will have to provide his or her own ride to the event.
- If a bus driver is early to a bus pickup area, the bus driver will wait until the scheduled pickup time before leaving the designated area. The bus driver will not leave the pickup area early nor will they wait any longer than the scheduled pickup time.

DROPPING OFF ATHLETES

- The bus driver will drop off the athletes at the designated area only! It is the responsibility of the parent to provide transportation from the designated bus stop areas. If a parent is not at the designated drop-off area, the student may lose transportation privileges for the remainder of the athletic season.
- The coaches will provide the athlete with an approximate drop off time, so parents can be there to meet the bus.
- The bus driver is not required to wait for the athletes to be picked up from the designated drop off area.

I have read the above requirements and agree to all terms and conditions. Failure to comply with the athletic transportation procedures may result in the loss of transportation services.

STUDENT ATHLETE'S NAME: _____

SIGNATURE: _____ **DATE:** _____

PARENT'S NAME: _____

SIGNATURE: _____ **DATE:** _____

***** THIS DOES NOT APPLY IF YOU LIVE IN BERNALILLO CITY LIMITS *****



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STUDENT ATHLETIC TRAVEL WAIVER

Dear Mr. Tapia, and Principals,

As parents/legal guardians we understand that the Bernalillo Public Schools (BPS) strives to maintain consistency in providing supervision, safety, and secure transportation for all student athletes as they compete around the State of New Mexico. We accept that BPS has informed us of the districts, and New Mexico Activities Associations, position specific to student athlete transportation to and from a scheduled event. As BPS continues with its review of this, we the parents/ legal guardians accept full responsibility in providing transportation for our child as per the schedule below.

As BPS continues to extend its commitment to respect and honor the parent/guardian/community and or villages, individuals, family, culture and/or spiritual responsibilities we agree to transfer responsibility to the parent/guardian specific to transportation to and from student athletic events.

This agreement allows parents/legal guardians to transport the student athlete in the family's personal vehicle. This agreement does not include any other student athlete. The parent/legal guardian is aware that this is an official waiver of the respective transportation position of the New Mexico Activities Association and the Bernalillo Public Schools. As this request comes directly from the parent/legal guardian with the respective signatures below BPS will allow the students athlete to travel with parent/legal guardian who acknowledge our position and maintain full responsibility for the named student.

Student Athlete

Date

Parent/Legal Guardian

Date

Head Coach

Date

Athletic Director

Date



BERNALILLO PUBLIC SCHOOLS

560 S. Camino Del Pueblo, Bernalillo NM 87004

Parent/Guardian Consent to Participate

I/ We, _____ the parent's/guardian's hereby give my consent for my child, _____ to participate in the interscholastic athletics for Bernalillo Public Schools (BPS) and authorize BPS to provide this information to the New Mexico Athletics Association (NMAA). The financial responsibility for securing care of the athlete's injuries is a matter between the parent's/guardian's and the health care practitioner of the parent's/guardian's selection. The athlete must have verifiable health insurance. BPS will not pay any health care practitioner for the treatment of any student athlete.

Parent/Guardian Sign Here: _____ Date: _____

Acknowledgement of Risk of Injury

I/We, _____ the Parent's/Guardian's, and the student athlete are aware that preparation for and participation in interscholastic athletics involves many risks and possibility of serious and permanent injury to the student athlete. We understand and acknowledge the danger of the possibility of a serious and permanent injury being inherent in physical activity, which may involve vigorous physical contact.

Parent/Guardian Sign Here: _____ Date: _____

Student Athlete Sign Here: _____ Date: _____

Personal Medication Notification

For my own protection, I, _____ the student athlete will notify the sports physician for the athletic trainer if I am taking any medication or using any topical ointments, liniments, or balms. I will also bring it to their attention if I have a prosthetic/metal implant in my body before receiving therapy or treatment of any kind in the training room. Note: (Any combination of the above and deep heat therapy i.e, ultrasound could cause serious complications).

I/We, _____ the parent's/guardian's and the student athlete have read, and fully understand the consequence with failure to divulge this information.

Parent/Guardian Sign Here: _____ Date: _____

Student Athlete Sign Here: _____ Date: _____



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ATHLETIC PARTICIPATION INFORMATION

Student Athlete Name: _____

Address: _____ City: _____ Zip: _____

Birth Date: _____ Age: _____ Grade: _____ Home Phone: _____

Father's Name: _____ Mother's Name: _____

Daytime Phone Number: Father: _____ Mother: _____

If an emergency and the parent/guardian cannot be reached, please notify:

_____ Phone Number: _____

Known Allergies: _____ Medication: _____

Health Insurance Carrier: _____ Policy Number: _____

EMERGENCY CONSENT TO TREAT

I/We _____ the parent's/guardian's request that I/We be contacted within a reasonable time frame in the event of an injury requiring medical attention. In the event I/We cannot be reached, I/We designate the Team Physician, Athletic Director, Head Coach, or his/her designee to act on my/our behalf to authorize treatment in an emergency situation resulting from injury while participating in BPS athletics. Permission is hereby granted to the licensed health care practitioner to proceed with any examination, medical or minor surgical treatment, and x-ray/diagnostic imaging for the above named student athlete. In the event of an emergency arising out of serious injury requiring the need for major surgery, I/We understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If said licensed health practitioner is not able to communicate with me, I authorize the licensed health care practitioner to provide the necessary treatment that would be in the best interest of the student athlete. Permission is also granted to the certified sports physician or certified athletic trainer to provide the needed emergency treatment prior to admission to a medical facility.

Parent/Guardian Sign Here: _____ Date: _____

HEALTH INSURANCE INFORMATION

(MANDATORY)

I/We, _____ the parent's/guardian's certify that I/We have health insurance for my/our child with _____ Insurance Company and that it will remain effective throughout the ENTIRE athletic season that they are participating in.

Parent/Guardian Sign Here: _____ Date: _____

I/We, _____ the parent's/guardian's do not have health insurance and wish to purchase Student Accident Insurance through BPS

Parent/Guardian Sign Here: _____ Date: _____



BERNALILLO PRE-PARTICIPATIN PHYSICAL EXAM PACKET

***** PLEASE PRINT CLEARLY *****

Parent/Guardian please fill out prior to examination.

Student Athlete Name (Last, First, M.I.): _____

Home Address: _____

Grade: _____ Age: _____ Date Of Birth: _____

Name of Parent/Guardian: _____

Home Address: _____

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

EMERGENCY CONTACT: (Other Than Parents):

Name: _____ Relationship: _____

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

Address : _____

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

SPORTS/ACTIVITIES

FALL

FOOTBALL _____
CROSS COUNTRY _____
BOYS SOCCER _____
GIRLS SOCCER _____
VOLLEYBALL _____
CHEER _____
GOLF _____

WINTER

BOYS BASKETBALL _____
GIRLS BASKETBALL _____
WRESTLING _____

SRING

BASEBALL _____
GOLF _____
SOFTBALL _____
BOYS TRACK _____
GIRLS TRACK _____
TENNIS _____

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 ON EACH PAGE OF THE FORM AND RETURN THE ENTIRE PACKAGE WITH A COPY OF YOUR INSURANCE CARD TO THE SCHOOL'S ATHLETIC TRAINER.



CLEARED TO PARTICIPATE & EMERGENCY INFORMATION FORM

Student Athlete Name: _____ Grade: _____ D.O.B. _____

This student has turned in the following information to the BPS Athletic Trainer. To the best of my knowledge it is complete and accurate and this student is now cleared to begin practicing/ participating. The head coach is responsible for having this document readily available for travel.

EMERGENCY INFORMATION:

Mother's Name: _____ Phone: (H): _____ (W): _____ (C): _____

Father's Name: _____ Phone: (H): _____ (W): _____ (C): _____

Home Address: _____

Emergency Contact (Other than parent):

Name : _____ Relationship: _____

Phone: _____ Cell: _____

Medical History:

Allergies: _____ History of Anaphylaxis _____ Y _____ N

Immunizations: _____ (up to date) Last Tetanus Immunization: _____

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

Current Medical Conditions: _____

Current Medications: (If Asthma medications please indicate if needed prior to sport): _____

Does Athlete wear contacts? ____Y ____N Does Athlete require eye protection while playing ____Y ____N

Student's Primary Physician/Provider (For Follow Up, If Necessary): _____

Address: _____ Phone: _____

Hospital Preference: _____ (1st Choice) _____ (2nd Choice) _____

Insurance Provider: _____ Policy #: _____

BPS ATHLETIC TRAINER/ ATHLETIC DIRECTOR: _____