

# BOZEMAN HIGH SCHOOL "HAWK" ACTIVITY SCHEDULE 2017-2018



## **SCHEDULE IS TENTATIVE AND SUBJECT TO CHANGE**

(SPORTS PHYSICALS MUST BE DATED AFTER MAY 1, 2017 FOR THE 2017-18 SPORTS YEAR)

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### **FALL**

### **FIRST DAY – END DAY**

FOOTBALL	AUGUST 11 – NOVEMBER 17
GIRLS' VOLLEYBALL	AUGUST 11 – NOVEMBER 11
SOCCER	AUGUST 11 – OCTOBER 28
CROSS COUNTRY	AUGUST 14 – OCTOBER 21
GOLF	AUGUST 10 – SEPTEMBER 27
FALL CHEERLEADING/DANCE	AUGUST 11 – NOVEMBER 17
SPEECH & DEBATE	OCTOBER 2 – JANUARY 27

*FALL PARENT MEETING – WEDNESDAY, AUGUST 9, 2017 6:00 PM IN BHS SOUTH GYM.*

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### **WINTER**

### **FIRST DAY – END DAY**

WRESTLING	NOVEMBER 16 – FEBRUARY 10
SWIMMING	NOVEMBER 16 – FEBRUARY 10
GIRLS' BASKETBALL	NOVEMBER 16 – MARCH 11
BOYS' BASKETBALL	NOVEMBER 16 – MARCH 11
WINTER CHEERLEADING/DANCE	NOVEMBER 16 – MARCH 11
9-12 INTRAMURAL BASKETBALL	TO BE ANNOUNCED

*WINTER PARENT MEETING – WEDNESDAY, NOVEMBER 15, 2017 7:00 PM IN BHS SOUTH GYM.*

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### **SPRING**

### **FIRST DAY – END DAY**

TRACK & FIELD	MARCH 19 – MAY 26
GIRLS' FASTPITCH	MARCH 19 – MAY 26
TENNIS	MARCH 19 – MAY 19
9-12 INTRAMURAL SPRING	TO BE ANNOUNCED

*SPRING PARENT MEETING – MONDAY, MARCH 19, 2018 7:00 PM IN BHS SOUTH GYM.*

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*TRYOUTS FOR SOCCER, GOLF, VOLLEYBALL, BOYS' AND GIRLS' BASKETBALL, FASTPITCH, AND TENNIS BEGIN ON THE FIRST DAY OF PRACTICE. LATE TRYOUTS ARE ONLY PERMITTED IN CIRCUMSTANCES BEYOND A FAMILY'S CONTROL AND APPROVED BY THE ACTIVITIES DIRECTOR. ADDITIONAL INFORMATION CAN BE FOUND [WWW.BSD7.ORG](http://WWW.BSD7.ORG) QUICK LINKS - ACTIVITIES*

ALL ACTIVITIES

# BOZEMAN HIGH SPORT/ACTIVITY REGISTRATION INSTRUCTIONS

1. Complete and Submit Sports Form On Line; Online forms will be available beginning August 1, 2017 in Powerschool
2. Submit Current Sports Physical to Activities Office. Must be dated May 1, 2017 or later to be valid for the 2017-2018 school year. Sports Physical form can be found on *bsd7.org* Quick Links-Activities
3. Submit Sports Fee to Activities Office – \$100.00/High School Sport (Cheer - \$50.00/Season)

## INSTRUCTIONS TO SUBMIT SPORT FORM ONLINE:

Go to [www.bsd7.org](http://www.bsd7.org)

Under the “Students & Parents” tab go to “PowerSchool” to log into the parent portal.

Sign parent portal as “PARENT” using your username and password, if you do not have this information please follow instructions on page for help guidelines.

Once signed into the parent portal, on the left hand side of your student page will be a “Forms” option - click to open page the Forms page

Click to open form named “High School Athletic Form for BHS”

READ ALL INFORMATION – INCLUDING LINKS TO POLICIES

Fill in required fields at bottom of page and submit.

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**Online Form Submission is MANDATORY**

**PARENT/LEGAL GUARDIAN must complete prior to student signing up for a sport.**

**Completed sports physical dated after May 1, 2017 and fee of \$100.00 to Activities Office can be turned in once the parent/legal guardian has submitted online form to complete the registration.**

**Online form submission will be verified by the Activities Office at time sports physical and \$100.00 fee is paid – please make sure you have completed the online forms!**

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## MHSА CONFIDENTIAL ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION

See Montana High School Association, Article II, Section (3), Physical Exam. A physical examination is required for each student in order to be considered eligible for participation in an Association contest. Physical examinations must be completed prior to the first practice. This examination must be certified by a licensed medical professional acting within the scope and limitations of his/her practice. This certification is valid for a period of one school year. A physical examination conducted before May 1<sup>st</sup> is not valid for participation for the following school year. All information is to remain confidential.

**HISTORY** -- To be completed by the student and parent(s).

QUESTIONNAIRE FOR ATHLETIC PARTICIPATION (PLEASE PRINT)			
Name _____	Male _____	Female _____	Date of Birth _____ Grade _____
Home Address _____		Phone Number _____	
Parent's Name _____		Family Physician _____	
Current School _____			
Date _____		Student's Signature _____	

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

<p><b>Yes No</b></p> <p>1. Has a doctor ever denied or restricted your participation in sports for any reason? <input type="checkbox"/> <input type="checkbox"/></p> <p>2. Do you have an ongoing medical condition (like diabetes or asthma)? <input type="checkbox"/> <input type="checkbox"/></p> <p>3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? <input type="checkbox"/> <input type="checkbox"/></p> <p>4. Are you taking medicine for ADHD? <input type="checkbox"/> <input type="checkbox"/></p> <p>5. Do you have allergies to medicines, pollens, foods, or stinging insects? <input type="checkbox"/> <input type="checkbox"/></p> <p>6. Have you ever passed out or nearly passed out DURING exercise? <input type="checkbox"/> <input type="checkbox"/></p> <p>7. Have you ever passed out or nearly passed out AFTER exercise? <input type="checkbox"/> <input type="checkbox"/></p> <p>8. Have you ever had discomfort, pain, or pressure in your chest during exercise? <input type="checkbox"/> <input type="checkbox"/></p> <p>9. Does your heart race or skip beats during exercise? <input type="checkbox"/> <input type="checkbox"/></p> <p>10. Has a doctor ever told you that you have (circle all that apply):              High blood pressure      A heart murmur              High cholesterol        A heart infection</p> <p>11. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram) <input type="checkbox"/> <input type="checkbox"/></p> <p>12. Has anyone in your family died for no apparent reason? <input type="checkbox"/> <input type="checkbox"/></p> <p>13. Does anyone in your family have a heart problem? <input type="checkbox"/> <input type="checkbox"/></p> <p>14. Has any family member or relative died of heart problems or of sudden death before age 50? <input type="checkbox"/> <input type="checkbox"/></p> <p>15. Does anyone in your family have Marfan syndrome? <input type="checkbox"/> <input type="checkbox"/></p> <p>16. Have you ever spent the night in a hospital? <input type="checkbox"/> <input type="checkbox"/></p> <p>17. Have you ever had surgery? <input type="checkbox"/> <input type="checkbox"/></p> <p>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? If yes, circle affected area below:              <input type="checkbox"/> <input type="checkbox"/></p> <p>19. Have you had any broken or fractured bones, or dislocated joints? If yes, circle below: <input type="checkbox"/> <input type="checkbox"/></p> <p>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? If yes, circle below:  <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"> <tr> <td style="padding: 2px;">Head</td> <td style="padding: 2px;">Neck</td> <td style="padding: 2px;">Shoulder</td> <td style="padding: 2px;">Upper arm</td> <td style="padding: 2px;">Elbow</td> <td style="padding: 2px;">Forearm</td> <td style="padding: 2px;">Hand / fingers</td> <td style="padding: 2px;">Chest</td> </tr> <tr> <td style="padding: 2px;">Upper back</td> <td style="padding: 2px;">Lower back</td> <td style="padding: 2px;">Hip</td> <td style="padding: 2px;">Thigh</td> <td style="padding: 2px;">Knee</td> <td style="padding: 2px;">Calf/shin</td> <td style="padding: 2px;">Ankle</td> <td style="padding: 2px;">Foot / toes</td> </tr> </table> </p> <p>21. Have you ever had a stress fracture? <input type="checkbox"/> <input type="checkbox"/></p> <p>22. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? <input type="checkbox"/> <input type="checkbox"/></p> <p>23. Do you regularly use a brace or assistive device? <input type="checkbox"/> <input type="checkbox"/></p> <p>24. Has a doctor ever told you that you have asthma or allergies? <input type="checkbox"/> <input type="checkbox"/></p>	Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand / fingers	Chest	Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot / toes	<p><b>Yes No</b></p> <p>25. Do you cough, wheeze, or have difficulty breathing during or after exercise? <input type="checkbox"/> <input type="checkbox"/></p> <p>26. Is there anyone in your family who has asthma? <input type="checkbox"/> <input type="checkbox"/></p> <p>27. Have you ever used an inhaler or taken asthma medicine? <input type="checkbox"/> <input type="checkbox"/></p> <p>28. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? <input type="checkbox"/> <input type="checkbox"/></p> <p>29. Have you had infectious mononucleosis (mono) within the last month? <input type="checkbox"/> <input type="checkbox"/></p> <p>30. Do you have any rashes, pressure sores, or other skin problems? <input type="checkbox"/> <input type="checkbox"/></p> <p>31. Have you had a herpes skin infection? <input type="checkbox"/> <input type="checkbox"/></p> <p>32. Have you ever had a head injury or concussion? <input type="checkbox"/> <input type="checkbox"/></p> <p>33. Have you been hit in the head and been confused or lost your memory? <input type="checkbox"/> <input type="checkbox"/></p> <p>34. Have you ever had a seizure? <input type="checkbox"/> <input type="checkbox"/></p> <p>35. Do you have headaches with exercise? <input type="checkbox"/> <input type="checkbox"/></p> <p>36. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? <input type="checkbox"/> <input type="checkbox"/></p> <p>37. Have you ever been unable to move your arms or legs after being hit or falling? <input type="checkbox"/> <input type="checkbox"/></p> <p>38. When exercising in the heat, do you have severe muscle cramps or become ill? <input type="checkbox"/> <input type="checkbox"/></p> <p>39. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? <input type="checkbox"/> <input type="checkbox"/></p> <p>40. Have you had any problems with your eyes or visions? <input type="checkbox"/> <input type="checkbox"/></p> <p>41. Do you wear glasses or contact lenses? <input type="checkbox"/> <input type="checkbox"/></p> <p>42. Do you wear protective eyewear, such as goggles or a face shield? <input type="checkbox"/> <input type="checkbox"/></p> <p>43. Are you happy with your weight? <input type="checkbox"/> <input type="checkbox"/></p> <p>44. Are you trying to gain or lose weight? <input type="checkbox"/> <input type="checkbox"/></p> <p>45. Have anyone recommended you change your weight or eating habits? <input type="checkbox"/> <input type="checkbox"/></p> <p>46. Do you limit or carefully control what you eat? <input type="checkbox"/> <input type="checkbox"/></p> <p>47. Do you have any concerns that you would like to discuss with a doctor? <input type="checkbox"/> <input type="checkbox"/></p> <p><b>FEMALES ONLY</b></p> <p>48. Have you ever had a menstrual period? <input type="checkbox"/> <input type="checkbox"/></p> <p>49. How old were you when you had your first menstrual period? <input type="checkbox"/> <input type="checkbox"/></p> <p>50. How many periods have you had in the last year? <input type="checkbox"/> <input type="checkbox"/></p> <p>Explain "Yes" answers here:          _____          _____          _____          _____          _____          _____          _____          _____</p>
Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand / fingers	Chest										
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot / toes										

**Allergies:** \_\_\_\_\_

**Immunizations:** (eg, tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis, pneumococcal; meningococcal, varicella)

\_\_\_\_\_

**Date of last known tetanus shot:** \_\_\_\_\_

**PROVIDER'S PHYSICAL EXAMINATION FORM**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ BP: Left Arm \_\_\_\_\_ / \_\_\_\_\_ Right Arm \_\_\_\_\_ / \_\_\_\_\_  
 Vision R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Corrected: Y N Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

NORMAL	ABNORMAL FINDINGS	INITIALS
Appearance		
Eyes/ears/nose/throat		
Hearing		
Lymph nodes		
Heart		
Murmurs		
Pulses		
Lungs		
Abdomen		
Hernia		
Skin		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hands/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		

\*Multiple examiner set-up only.

Notes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**CLEARANCE**

Cleared without restriction  
 Cleared with recommendations for further evaluation or treatment for: \_\_\_\_\_

Not cleared for  All sports  Certain sports \_\_\_\_\_ Reason: \_\_\_\_\_  
 Recommendations: \_\_\_\_\_

Name of physician/medical provider (print or type) \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_  
 Signature of physician/medical provider \_\_\_\_\_

**PARENT'S OR GUARDIAN'S PERMISSION AND RELEASE**

I certify that the information provided by the student/parent(s) is accurate to the best of my knowledge. I hereby give my consent for the above student to engage in approved athletic activities as a representative of his/her school, except those indicated above by the licensed professional. I also give my permission for the team physician, athletic trainer, or other qualified personnel to have access to information provided here as well as to give first aid treatment to this student at an athletic event in case of injury. If emergency service involving medical action or treatment is required and the parents(s) or guardian(s) cannot be contacted, I hereby consent for the student named above to be given medical care by the doctor or hospital selected by the school.

Typed or printed name of parent or guardian \_\_\_\_\_ Signature of parent or guardian \_\_\_\_\_  
 Date \_\_\_\_\_ Address \_\_\_\_\_ Insurance (Company name) \_\_\_\_\_  
 Parent's Home Phone \_\_\_\_\_ Parent's Work Phone \_\_\_\_\_ Parent's Cell Phone \_\_\_\_\_ Additional Phone (if any-specify) \_\_\_\_\_

**ALL INFORMATION IS TO REMAIN CONFIDENTIAL**

(Revised 4/09)

**VERIFICATION OF INSURANCE:** The School District **DOES NOT** provide medical insurance benefits for students who choose to participate in sports programs. Medical insurance **MUST BE PROVIDED** in order for the student to participate. "NorthWestern Scholastic Insurance" forms for coverage during sports are available in the Activities Office. **THE ATHLETE IS COVERED WITH THE FOLLOWING HEALTH INSURANCE:**

**INSURANCE** (Company Name) \_\_\_\_\_ **POLICY #** \_\_\_\_\_

**PARENT MUST COMPLETE**

