



Red Rock Elementary School
20854 E Homestead Drive, Red Rock, AZ 85145
(520) 682-3331

2026-2027

ATHLETIC PACKET

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**ALL FORMS MUST BE COMPLETED AND RETURNED TO THE ATHLETIC
DIRECTOR PRIOR TO THE FIRST DAY OF PRACTICE**

Red Rock Athletics

Baylee Slaughter
Athletic Director
(520) 682-3331 ex. 2432 | bslaughter@redrockschools.com



Code of Conduct for Parents and Spectators

As a spectator attending a Red Rock K-8 School athletic event:

- I recognize
that the goal of this event is to provide young people with the opportunity for healthy competition in the spirit of sportsmanship and camaraderie.
- I recognize
that I have a role to protect a positive and supportive attitude toward the participants, coaches, officials, school authorities, and fellow spectators of the event.
- I recognize
that my words and behavior have a powerful impact on those around me and that I have a role to conduct myself in a mature and dignified manner.
- I recognize
that for the orderly management of the athletic events, I have a role to adhere to the direction stated by school authorities.
- I recognize
that if my conduct is not conducive to a positive environment, I will be asked to leave an athletic event.

High expectations for sportsmanship behavior of athletes and fans are imperative in carrying out the mission of the Northwest League. Each school is responsible for maintaining appropriate behavior during athletic contests. Please be advised that all campuses in the Northwest League are tobacco-free. Whether you are an athlete or a spectator, we ask for your cooperation in helping us maintain high standards.

This form must be signed and returned before participation in games. We have read and understand the Athletic Code of Conduct for Parents and Spectators

Student's Name _____ Sport _____
(Please print)

Parent Name & Signature _____ Date _____



Student Athlete Code of Conduct

Participating in the Red Rock Elementary School Athletic Program is a privilege. If the student-athlete cannot represent their team, themselves, and their school in a respectable manner, this privilege will be taken away. In order to reach the team's full potential, the individual will be responsible to abide by the following conditions.

- **All participants are students first and athletes second.**
 - This means if a student cannot perform in the classroom, they cannot perform on the field/court. If a student receives an in-school suspension, they will be ineligible to play in their next game. If a student receives a second in-school suspension or out-of-school suspension, they may be suspended indefinitely from the team.
- **Athletes must meet the school's academic requirements**
 - Each athlete must maintain passing grades in all classes.
 - Grade Checks will be conducted for all student-athletes during the sports seasons.
 - Students will be eligible to return to play *after* their grades improve.
- **Attendance at all practice and games is mandatory.**
 - Doctors, parents, or teachers may excuse athletes if done prior to an event. Student-athletes must present a written letter to their coach, or have a parent call a coach, to excuse their child.
- **Athletes must demonstrate sportsmanship during all competitions/games.**

Any display of unsportsmanlike conduct will result in consequences.

 - 1st occurrence = Verbal reprimand from coach or athletic director.
 - 2nd occurrence = Must sit the bench for a period of time during activity.
 - 3rd occurrence = Athlete is suspended for at least one game.
 - 4th occurrence = Athlete is dismissed from sport and must turn their uniform into the coach
- **Athletes must conduct themselves in a respectful manner at all times during away games.**
 - Any act of anger or disrespect toward a teammate, coach, opponent, official, or adult will result in a loss of playing time and possibly suspension. This includes obeying the bus rules.

This form must be signed and returned before participation in games. We have read and understand the Student Athlete Code of Conduct.

Student's Name & Signature _____ Date _____

Parent Name & Signature _____ Date _____



Transportation Regulations

Athletic staff and student athletes represent the district at all times. When being transported by district transports, all transportation rules and regulations are in effect. The transportation driver is responsible for ensuring that all district, state, and federal regulations are followed. All members of the athletic staff should cooperate with the requests made by the driver.

Parent Request to Transport a Student Athlete

I/We _____ and _____, parents or legal guardians of _____ wish to provide transportation for our son/daughter for _____ to be held at _____ activity

_____ site/sites

_____ Please check here if you will be providing transportation home from every game

_____ Please check here if you will be providing transportation on occasion

_____ Please check here if you are authorizing another adult to transport your child.

Have them sign here:

Transporting Adult Name & Signature (not parent)

Date

Transporting Adult Contact Info: _____

I/We understand that we are waiving any claims I/We may have against Red Rock Elementary School District and relieving the district of any liability regarding the safe transport of my/our child.

I/We understand that I/We may transport ONLY my/our child from the athletic contest unless we have an authorized transporting adult (stated above) and that this approval must be on file in the Principal's office.

Parent/Guardian Signature _____ Date _____

Accepted by: _____ Date _____
School Administrator



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Athletic Participation Consent Form

I give permission for _____ to participate in organized athletics at Red Rock Elementary School realizing that such activities involve the potential for injury, which is inherent in all sports. I acknowledge that even with the best of circumstances that injury can occur.

_____ (Initial) I acknowledge that I have read and understand the above warning.

_____ (Initial) I also certify that we do have medical and hospital insurance to cover the above named student.

Insurance Company _____ Policy # _____

Parent/Guardian Signature _____ Date _____

Parent/Guardian Phone # _____

Consent for Emergency Care

Student Name: _____: I, the undersigned parent/guardian of the student named, do hereby give and grant unto any medical doctor or hospital my consent and authorization to render such aid, treatment, or care to said student, as in the judgment or said doctor or hospital may be required, on any emergency basis, in the event said student should be injured or stricken ill while participating in an athletic activity, sponsored or sanctioned by the Red Rock Elementary School Athletic Department.

It is hereby understood that the consent and authorization hereby given and granted is continuing and is intended to extend throughout the current school year.

Family Doctor _____ Phone # _____

Allergies _____

In an emergency, if a parent cannot be contacted, please notify:

Name _____ Relationship _____ Phone # _____



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Athletic Participation Fee

There is an \$85 participation fee for Athletics. This fee covers costs for transportation, uniforms, equipment, and participation in the Northwest League.

Student First & Last Name: _____

_____ (Initial) I acknowledge that this is a non-refundable fee

Currency: _____

Parent/Guardian Name _____

Parent/Guardian Signature _____ Date _____

Please make checks payable to **Red Rock Elementary School**

Memo: **Athletic Fee**

Turn in Athletic Packet to Baylee Slaughter, and Athletic Fee to Cathy Shull.

Baylee Slaughter

Athletic Director

520-682-3331 ext. 2432

Cathy Shull

Business Manager

520-682-3331

2026-27 CONSENT TO TREAT FORM

Parental consent for minor athletes is generally required for sports medicine services, defined as services including, but not limited to, evaluation, diagnosis, first aid and emergency care, stabilization, treatment, rehabilitation and referral of injuries and illnesses, along with decisions on return to play after injury or illness. Occasionally, those minor athletes require sports medicine services before, during and after their participation in sport-related activities, and under circumstances in which a parent or legal guardian is not immediately available to provide consent pertaining to the specific condition affecting the athlete. In such instances it may be imperative to the health and safety of those athletes that sports medicine services necessary to prevent harm be provided immediately, and not be withheld or delayed because of problems obtaining consent of a parent/guardian.

Accordingly, as a member of the Arizona Interscholastic Association (AIA), _____ (name of school or district) requires as a pre-condition of participation in interscholastic activities, that a parent/guardian provide written consent to the rendering of necessary sports medicine services to their minor athlete by a qualified medical provider (QMP) employed or otherwise designated by the school/district/AIA, to the extent the QMP deems necessary to prevent harm to the student-athlete. It is understood that a QMP may be an athletic trainer, physician, physician assistant or nurse practitioner licensed by the state of Arizona (or the state in which the student-athlete is located at the time the injury/illness occurs), and who is acting in accordance with the scope of practice under their designated state license and any other requirement imposed by Arizona law. In emergency situations, the QMP may also be a certified paramedic or emergency medical technician, but only for the purpose of providing emergency care and transport as designate

PLEASE PRINT LEGIBLY OR TYPE

"I, _____, the undersigned, am the parent/legal guardian of, _____, a minor and student-athlete at _____ (name of school or district) who intends to participate in interscholastic sports and/or activities.

I understand that the school/district/AIA employs or designates QMP's (as defined above) to provide sports medicine services (as also defined above) to the school's interscholastic athletes before, during or after sport-related activities, and that on certain occasions there are sport-related activities conducted away from the school/district facilities during which other QMP's are responsible for providing such sports medicine services. I hereby give consent to any such QMP to provide any such sports medicine services to the above-named minor. The QMP may make decisions on return to play in accordance with the defined scope of practice under the designated state license, except as otherwise limited by Arizona law. I also understand that documentation pertaining to any sports medicine services provided to the above-named minor, may be maintained by the QMP. I hereby authorize the QMP who provides such services to the above-named minor to disclose such information about the athlete's injury/illness, assessment, condition, treatment, rehabilitation and return to play status to those who, in the professional judgment of the QMP, are required to have such information in order to assure optimum treatment for and recovery from the injury/illness, and to protect the health and safety of the minor. I understand such disclosures may be made to above-named minor's coaches, athletic director, school nurse, any classroom teacher required to provide academic accommodation to assure the student-athlete's recovery and safe return to activity, and any treating QMP.

If the parent believes that the minor is in need of further treatment or rehabilitation services for the injury/illness, the minor may be treated by the physician or provider of his/her choice. I understand, however, that all decisions regarding same day return to activity following injury/illness shall be made by the QMP employed/designated by the school/district/AIA.

Date: _____ Signature: _____

**Arizona Interscholastic Association, Inc.
Mild Traumatic Brain Injury (MTBI) / Concussion
Annual Statement and Acknowledgement Form**

I, _____ (student), acknowledge that I have to be an active participant in my own health and have the direct responsibility for reporting all of my injuries and illnesses to the school staff (e.g., coaches, team physicians, athletic training staff). I further recognize that my physical condition is dependent upon providing an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries and/or disabilities experienced before, during or after athletic activities.

By signing below, I acknowledge:

- My institution has provided me with specific educational materials including the CDC Concussion fact sheet (<http://www.cdc.gov/concussion/HeadsUp/youth.html>) on what a concussion is and has given me an opportunity to ask questions.
- I have fully disclosed to the staff any prior medical conditions and will also disclose any future conditions.
- There is a possibility that participation in my sport may result in a head injury and/or concussion. In rare cases, these concussions can cause permanent brain damage, and even death.
- A concussion is a brain injury, which I am responsible for reporting to the team physician or athletic trainer.
- A concussion can affect my ability to perform everyday activities, and affect my reaction time, balance, sleep, and classroom performance.
- Some of the symptoms of concussion may be noticed right away while other symptoms can show up hours or days after the injury.
- If I suspect a teammate has a concussion, I am responsible for reporting the injury to the school staff.
- I will not return to play in a game or practice if I have received a blow to the head or body that results in concussion related symptoms.
- I will not return to play in a game or practice until my symptoms have resolved AND I have written clearance to do so by a qualified health care professional.
- Following concussion the brain needs time to heal and you are much more likely to have a repeat concussion or further damage if you return to play before your symptoms resolve.

Based on the incidence of concussion as published by the CDC the following sports have been identified as high risk for concussion; baseball, basketball, diving, football, pole vaulting, soccer, softball, spiritline and wrestling.

I represent and certify that I and my parent/guardian have read the entirety of this document and fully understand the contents, consequences and implications of signing this document and that I agree to be bound by this document.

Student Athlete:

Print Name: _____ Signature: _____ Date: _____

Parent or legal guardian must print and sign name below and indicate date signed:

Print Name: _____ Signature: _____ Date: _____

AIAARIZONA INTERSCHOLASTIC ASSOC.
OUR STUDENTS, OUR TEAMS ... OUR FUTURE**2026-27****ANNUAL PREPARTICIPATION
PHYSICAL EXAMINATION** **Banner.
Urgent Care**EXCLUSIVE URGENT CARE
PARTNER OF THE AIA

Name: _____ Date of Birth: _____

Age: _____ Sex: _____

Height: _____ Weight: _____ % Body Fat (optional): _____

Pulse: _____ Blood Pressure (1st measure): ____ / ____ (2nd measure) ____ / ____ (3rd measure) ____ / ____

Vision: R20/____ L20/____ Corrected: ☐ Y ☐ N Pupils: ☐ Equal ☐ Unequal

Medical	Normal	Abnormal
Appearance		
Eyes/Ears/Throat/Nose		
Hearing		
Lymph Nodes		
Heart		
Murmurs		
Pulses		
Lungs		
Abdomen		
Genitourinary&		
Skin		

Musculoskeletal	Normal	Abnormal
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hands/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		

A complete PPE requires the information below completed as text or with the official stamp of the provider's office.

* - Multi-examiner set-up only | & - Having a third party present is recommended for the genitourinary examination

NOTES AND RECOMMENDATIONS:

- ☐ Cleared without restriction for all sports
- ☐ Cleared with the following restrictions and/or recommendations: _____
- ☐ Not cleared for any sports [Reason(s)]: _____

Medical Professional has reviewed family history _____ (Initials) Exam Date: _____

Name of Medical Professional (Print/Type): _____

Address: _____

Phone: _____

Signature of Medical Professional: _____

Medical Credential (Circle): MD / DO / ND / NP / PA-C / CCSP

FORM 15.7-B 02/25/2026 (rev.) Banner Urgent Care is the preferred partner of the AIA. It is not required you visit Banner locations for your healthcare needs.

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(The parent or guardian should fill out this form with assistance from the student-athlete)

Exam Date: _____

Name: _____

Home Address: _____

Phone: _____

Date of Birth: _____

Age: _____

Sex Assigned at Birth: _____

Grade: _____

School: _____

Sport(s): _____

Personal Physician: _____

Hospital Preference: _____

In case of emergency contact:

Name: _____

Relationship: _____

Phone (Home): _____

Phone (Work): _____

Phone (Cell): _____

Name: _____

Relationship: _____

Phone (Home): _____

Phone (Work): _____

Phone (Cell): _____

Explain "Yes" answers on the following page.
Circle questions you don't know the answers to.

	Yes	No
1) Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2) List past and current medical conditions: _____	☐	☐
3) Are you currently taking any prescription or nonprescription (over-the-counter) medicines or supplements? (Please specify): _____	☐	☐
4) Do you have allergies to medicines, pollens, foods or stinging insects? (Please specify): _____	☐	☐
5) Does your heart race or skip beats during exercise?	☐	☐
6) Has a doctor ever told you that you have (check all that apply): ☐ High Blood Pressure ☐ A Heart Murmur ☐ High Cholesterol ☐ A Heart Infection		
7) Have you ever had surgery? (Please list): _____	☐	☐
8) Have you ever had an injury (sprain, muscle/ligament tear, tendinitis, etc.) that caused you to miss a practice or game? (If yes, check affected area in the box below in question 10)	☐	☐
9) Have you had any broken/fractured bones or dislocated joints? (If yes, check affected area in the box below in question 10):	☐	☐
10) Have you had a bone/joint injury that required X-rays, MRI, CT, surgery, injections, rehabilitation physical therapy, a brace, a cast or crutches? (If yes, check affected area in the box below):	☐	☐
☐ Head ☐ Neck ☐ Shoulder ☐ Upper Arm ☐ Elbow ☐ Forearm		
☐ Hand/Fingers ☐ Chest ☐ Upper Back ☐ Lower Back ☐ Hip ☐ Thigh		
☐ Knee ☐ Calf/Shin ☐ Ankle ☐ Foot/Toes		

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	Yes	No
11) Have you ever had a stress fracture?	☐	☐
12) Have you ever been told that you have, or have you had an X-ray for atlantoaxial (neck) instability?	☐	☐
13) Do you regularly use a brace or assistive device?	☐	☐
14) Has a doctor told you that you have asthma or allergies?	☐	☐
15) Do you cough, wheeze or have difficulty breathing during or after exercise?	☐	☐
16) Have you ever used an inhaler or taken asthma medication?	☐	☐
17) Do you have groin or testicular pain, or a painful bulge or hernia in the groin area?	☐	☐
18) Were you born without, are you missing, or do you have a non-functioning kidney, eye, testicle or any other organ?	☐	☐
19) Have you had infectious mononucleosis (mono) within the last month?	☐	☐
20) Do you have any rashes, pressure sores or other skin problems?	☐	☐
21) Have you had a herpes skin infection?	☐	☐
22) Have you ever had an injury to your face, head, skull or brain (including a concussion, confusion, memory loss or headache from a hit to your head, having your "bell rung" or getting "dinged")?	☐	☐
23) Have you ever had a seizure?	☐	☐
24) Have you ever had numbness, tingling or weakness in your arms or legs after being hit, falling, stingers or burners?	☐	☐
25) While exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
26) Have you or someone in your family tested positive for sickle cell trait or sickle cell disease?	☐	☐
27) Have you been hospitalized or had long-term complication care due to COVID-19?	☐	☐
28) Are you happy with your weight?	☐	☐
29) Are you trying to gain or lose weight?	☐	☐
30) Has anyone recommended you change your weight or eating habits?	☐	☐
31) Do you limit or carefully control what you eat?	☐	☐
32) Do you have any concerns that you would like to discuss with a doctor?	☐	☐

Females Only**Explain "Yes" Answers Here**

	Yes	No
33) Have you ever had a menstrual period?	☐	☐
34) How old were you when you had your first menstrual period?	_____	
35) How many periods have you had in the last year?	_____	

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Student Name: _____

Date of Birth: _____

Patient History Questions: Please Share About Your Child

	Yes	No
1) Has your child fainted or passed out DURING or AFTER exercise, emotion or startle?	☐	☐
2) Has your child ever had extreme shortness of breath during exercise?	☐	☐
3) Has your child had extreme fatigue associated with exercise (different from other children)?	☐	☐
4) Has your child ever had discomfort, pain or pressure in his/her chest during exercise?	☐	☐
5) Has a doctor ever ordered a test for your child's heart?	☐	☐
6) Has your child ever been diagnosed with an unexplained seizure disorder?	☐	☐
7) Has your child ever been diagnosed with exercise-induced asthma not well controlled with medication?	☐	☐

Explain "Yes" Answers Here**Patient Health Questionnaire Version 4 (PHQ-4)**

Over the last two weeks, how often have you been bothered by any of the following problems? (circle responses)

	Not At All	Several Days	Over Half The Days	Nearly Every Day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Share Any Notes Related To The Above Section

Family History Questions: Please Share About Any Of The Following In Your Family

	Yes	No		Yes	No
1) Are there any family members who had sudden/unexpected/unexplained death before age 50? (including SIDS, car accidents drowning or near drowning)	☐	☐			
2) Are there any family members who died suddenly of "heart problems" before age 50?	☐	☐			
3) Are there any family members who have unexplained fainting or seizures?	☐	☐			
4) Are there any relatives with certain conditions, such as:					
	Yes	No		Yes	No
Enlarged Heart	☐	☐	Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT)	☐	☐
Hypertrophic Cardiomyopathy (HCM)	☐	☐	Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)	☐	☐
Dilated Cardiomyopathy (DCM)	☐	☐	Marfan Syndrome (Aortic Rupture)	☐	☐
Heart Rhythm Problems	☐	☐	Heart Attack, Age 50 or Younger	☐	☐
Long QT Syndrome (LQTS)	☐	☐	Pacemaker or Implanted Defibrillator	☐	☐
Short QT Syndrome	☐	☐	Deaf at Birth	☐	☐
Brugada Syndrome	☐	☐			

Explain "Yes" Answers Here

Additional History

	Yes	No
1) Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff or dip?	☐	☐
2) Do you drink alcohol or use illicit drugs?	☐	☐
3) Have you ever taken anabolic steroids or used any other performance-enhancing supplements?	☐	☐
4) Have you ever taken any supplements to help you gain or lose weight, or improve your performance?	☐	☐
5) Do you always wear a seatbelt while in a vehicle?	☐	☐

I hereby state that, to the best of my knowledge, my answers to all of the above questions are complete and correct. Furthermore, I acknowledge and understand that my eligibility may be revoked if I have not given truthful and accurate information in response to the above questions.

Signature of Student-Athlete

Signature of Parent/Guardian

Date