WESTERN DUBUQUE COMMUNITY SCHOOL DISTRICT

ATHLETIC PARTICIPATION REQUIRED FORMS

(Required for Student Athletes)

STUDENT INFORMATION

STUDENT NAME:		AGE:	GRADE:	DATE OF BIRTH (MM/DD/YYYY)
ADDRESS:		CITY:		ZIP:
HOME PHONE:	CELL PHONE:	EMAIL:		

PARENT/GUARDIAN INFORMATION

PARENT/GUARDIAN NAME:		EMPLOYER:
HOME PHONE:	CELL PHONE:	EMAIL:
PARENT/GUARDIAN NAME:		EMPLOYER:
HOME PHONE:	CELL PHONE:	EMAIL:

IN AN EMERGENCY, WHEN PARENTS (OR LEGAL GUARDIANS) CANNOT BE NOTIFIED, PLEASE CONTACT:

NAME:	RELATIONSHIP:	CELL PHONE:

ACADEMICS REQUIREMENTS

Western Dubuque Community School District will follow the IHSAA/IGHSAU guidelines for academic eligibility. The Iowa Department of Education guidelines requires students to pass **ALL** subjects at the end of each grading period (semester grades). If a student has failed one or more subjects, a period of ineligibility will be assessed. Middle School students will follow district Policy 503.41 academic eligibility.

DOCTOR'S PERMIT/PHYSICAL EXAMINATION

Every student participating in IHSAA and/or IGHSAU athletics, must have a valid physical on file with their school's Activities Office. Physicals are valid for one year (365 days) from the date of examination.

FAMILY PHYSICIAN:	PHONE:
PREFERRED HOSPITAL:	PHONE:
FAMILY DENTIST:	PHONE:
DO YOU WEAR: GLASSES [YES] [NO] CONTACTS [YES] [NO]	DENTURES [YES] [NO]
DATE OF LAST TETANUS BOOSTER:	

LIST ANY KNOWN ALLERGIES, DRUG REACTIONS, OR OTHER PERTINENT MEDICAL INFORMATION:

CONSENT FOR MEDICAL TREATMENT

Iowa law requires a parent's, or legal guardian's written consent before their son or daughter can receive emergency treatment, unless, in the opinion of physician, the treatment is necessary to prevent death or serious injury.

As the parent(s), or legal guardian(s), of the child named on this form, I (we) authorize emergency medical treatment or hospitalization that is necessary in the event of an accident or illness of my (our) child. I (we) understand that this written consent is given in advance of any specific diagnosis or hospital care. This written authorization is granted only after a reasonable effort has been made to contact me (us).

PARENT/GUARDIAN SIGNATURE _____ DATE _____

WDCCSD SCHOOL BOARD POLICY 503.4/503.42 PARTICIPATION CODE FOR ACTIVITIES

By affixing my signature to this form, I affirm that I have read the Participation Code for Activities. I understand all the rules governing participation in the Western Dubuque County Community School District activities programs and I agree to abide by those rules.

STUDENT'S SIGNATURE _____ PARENT/GUARDIAN SIGNATURE _____

NOTE: If you wish to save data typed into this form, first save the file on your computer and re-open from your computer prior to typing. 01/2016

Please fill out this entire form

IOWA ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION

ARTICLE VII 36.14(1) PHYSICAL EXAMINATION. Every year each student (grades 7-12) shall present to the student's superintendent a certificate *signed by a licensed physician and surgeon, osteopathic physician and surgeon, osteopath, advanced registered nurse practitioner (ARNP), physician's assistant or qualified doctor of chiropractic*, to the effect that the student has been examined and may safely engage in athletic competition. *This certificate of physical examination is valid for the purposes of this rule for one (1) calendar year. A grace period, not to exceed thirty (30) days, is allowed for expired certifications of physical examination.*

QUESTIONNAIRE FOR ATHLETIC PARTICIPATION (Please type or neatly print this information)

STUDENT NAME:	FEMALE ___MALE___	DATE OF BIRTH (MM/DD/YYYY)	
HOME ADDRESS:		CITY:	ZIP:
SCHOOL DISTRICT:		GRADE:	DATE:
PARENT/GUARDIAN NAME:			
HOME PHONE:	CELL PHONE:		
FAMILY PHYSICIAN:	PHONE:		

HEALTH HISTORY

The following questions should be completed by the student-athlete with the assistance of a parent or guardian. A parent or guardian is required to sign on the other side of this form after the examination.

	YES	NO	DOES THIS STUDENT HAVE/EVER HAD?
1.			Allergies to medication, pollen, stinging insects, food, etc.
2.			Any illness lasting more than one (1) week?
3.			Asthma or difficulty breathing during exercise?
4.			Chronic or recurrent illness or injury?
5.			Diabetes?
6.			Epilepsy or other seizures?
7.			Eyeglasses or contacts?
8.			Herpes or MRSA?
9.			Hospitalizations (Overnight or longer)?
10.			Marfan Syndrome?
11.			Missing organ (eye, kidney, and testicle)?
12.			Mononucleosis or Rheumatic fever?
13.			Seizures or frequent headaches?
14.			Surgery?
15.			Chest pressure, pain, or tightness with exercise?
16.			Excessive shortness of breath with exercise?
17.			Headaches, dizziness or fainting during, or after, exercise?

	YES	NO	DOES THIS STUDENT HAVE/EVER HAD?
18.			Heart problems (Racing skipped beats, murmur, infection, etc.?)
19.			High blood pressure or high cholesterol?
20.			Head injury, concussion, unconsciousness?
21.			Headache, memory loss, or confusion with contact?
22.			Numbness, tingling or weakness in arms or legs with contact?
23.			Severe muscle cramps or illness when exercising in the heat?
24.			Fracture, stress fracture or dislocated joint(s)?
25.			Injuries requiring medical treatment?
26.			Knee injury or surgery?
27.			Neck injury?
28.			Orthotics, braces, protective equipment?
29.			Other serious joint injury?
30.			Painful bulge or hernia in the groin area?
31.			X-rays, MRI, CT scan, physical therapy?
32.			**Has a doctor ever denied or restricted your participation in sports for any reason?**
33.			**Do you have any concerns you would like to discuss with your health care provider?**

	YES	NO	FAMILY HISTORY
34.			Does anyone in your family have Marfan Syndrome?
35.			Has anyone in your family died of heart problems or any unexpected/unexplained reason before the age of 50?
36.			Does anyone in your family have a heart problem, pacemaker or implanted defibrillator?
37.			Has anyone in your family had unexplained fainting, seizures, or near drowning?
38.			Does anyone in your family have asthma?
39.			Do you or someone in your family have sickle cell trait or disease?
			Use this space to explain any **"YES"** answers from above (questions #1-38) or to **provide any additional information**.

40. Are you allergic to any prescription or over-the-counter medications? If yes, please list. _____

41. List all medications you are presently taking (including asthma inhalers & EpiPens) and the condition the medication is for:
A._____ B._____ C._____

42. Year of last known vaccination: Tetanus: _____ Meningitis: _____ Influenza: _____

43. What is the most and least you have weighed in the past year? Most_____ Least_____

44. Are you happy with your current weight? Yes ___ No ___ **If no**, how many pounds would you like to lose or gain? _____

FOR FEMALES ONLY
How old were you when you had your first menstrual periods?
How many periods have you had in the last 12 months?

PARENT/GUARDIAN MUST SIGN AT BOTTOM AFTER THIS FORM HAS BEEN COMPLETED BY A MEDICAL PROFESSIONAL

PHYSICAL EXAMINATION RECORD

To be completed by a licensed medical professional as designated in Article VII 36.14(1). ***This evaluation is only to determine readiness for sports participation. It should NOT be used as a substitute for regular health maintenance examinations.***

Athlete's Name:		Height:	Weight:
Pulse:	Blood Pressure: _____ / _____ (Repeat, if abnormal _____ / _____)	Vision: R 20 / _____	L 20 / _____

		NORMAL	ABNORMAL FINDINGS	INITIALS
1.	Appearance (esp. Marfan's)			
2.	Eyes/Ears/Nose/Throat			
3.	Pupil Size (Equal/Unequal)			
4.	Mouth/Teeth			
5.	Neck			
6.	Lymph Nodes			
7.	Heart (Standing & Lying)			
8.	Pulses (especially femoral)			
9.	Chest & Lungs			
10.	Abdomen			
11.	Skin			
12.	Genitals – Hernia			
13.	Musculoskeletal – ROM, strength, etc. (see questions 24-31)			
14.	Neurological			

Comments regarding abnormal findings: _____

LICENSED MEDICAL PROFESSIONAL'S ATHLETIC PARTICIPATION RECOMMENDATIONS

_____ **FULL AND UNLIMITED PARTICIPATION**

_____ **LIMITED PARTICIPATION** – May **NOT** participate in the following (checked):

____ Baseball ____ Basketball ____ Bowling ____ Cross Country ____ Football ____ Golf ____ Soccer
____ Softball ____ Swimming ____ Tennis ____ Track ____ Volleyball ____ Wrestling

_____ **CLEARANCE PENDING** – Document Follow-up to _____

_____ **NOT CLEARED FOR ATHLETIC PARTICIPATION** Due to _____

Licensed Medical Professional's Name (Printed) | **Date of PPE**

Licensed Medical Professional's Signature | **Phone**

PARENT'S OR GUARDIAN'S PERMISSION AND RELEASE

I hereby **verify** the accuracy of the information on the opposite side of this form and **give my consent** for the above named student to engage in approved athletic activities as a representative of his/her school, except those activities indicated above by the licensed professional. I also **give my permission** for the team's physician, certified athletic trainer, or other qualified personnel to give first aid treatment to my son or daughter at an athletic event in case of injury.

Name of Parent or Guardian (Printed) | **Signature of Parent or Guardian**

Address (Street/PO Box, City, State, Zip) | **Phone Number**

This form has been developed with the assistance of the Committee on Sports Medicine of the Iowa Medical Society and has been approved for use by the Iowa Department of Education, Iowa High School Athletic Association, and Iowa Girls High School Athletic Union. Schools are encouraged NOT to change this form from its published format. Additional school forms can be attached to this form. 9/12

HEADS UP: CONCUSSION IN HIGH SCHOOL SPORTS

The Iowa Legislature passed a new law, effective July 1, 2011, regarding students in grades 7 – 12 who participate in extracurricular interscholastic activities. Please note this important information from Iowa Code Section 280.13C, Brain Injury Policies:

1. A child must be immediately removed from participation (practice or competition) if his/her coach or a contest official observes signs, symptoms, or behaviors consistent with a concussion or brain injury in an extracurricular interscholastic activity.
2. A child may not participate again until a licensed health care provider trained in the evaluation and management of concussions and other brain injuries has evaluated him/her and the student has received written clearance from that person to return to participation.
3. Key definitions:
   "Licensed health care provider" means a physician, physician assistant, chiropractor, advanced registered nurse practitioner, nurse, physical therapist, or athletic trainer licensed by a board.
   "Extracurricular interscholastic activity" means any extracurricular interscholastic activity, contest, or practice, including sports, dance, or cheerleading.

What is a concussion?
A concussion is a brain injury. Concussions are caused by a bump, blow, or jolt to the head or body. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

What parents/guardians should do if they think their child has a concussion?

1. **OBEY THE NEW LAW.**
   a. Keep your child out of participation until s/he is cleared to return by a licensed healthcare provider.
   b. Seek medical attention right away.
2. Teach your child that it's not smart to play with a concussion.
3. Tell all of your child's coaches and the student's school nurse about ANY concussion.

What are the signs and symptoms of a concussion?
You cannot see a concussion. Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days after the injury. If your teen reports one or more symptoms of concussion listed below, or if you notice the symptoms yourself, keep your teen out of play and seek medical attention right away.

STUDENTS:

If you think you have a concussion:

- **Tell your coaches & parents –** Never ignore a bump or blow to the head, even if you feel fine. Also, tell your coach if you think one of your teammates might have a concussion.
- **Get a medical check-up –** A physician or other licensed health care provider can tell you if you have a concussion, and when it is OK to return to play.
- **Give yourself time to heal –** If you have a concussion, your brain needs time to heal. While your brain is healing, you are much more likely to have another concussion. It is important to rest and not return to play until you get the OK from your health care professional.

Signs reported by students:

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Just not "feeling right" or is "feeling down"

PARENTS:

How can you help your child prevent a concussion?
Every sport is different, but there are steps your children can take to protect themselves from concussion and other injuries.

- Make sure they wear the right protective equipment for their activity. It should fit properly, be well maintained, and be worn consistently and correctly.
- Ensure that they follow their coaches' rules for safety and
- The rules of the sport.
- Encourage them to practice good sportsmanship at all times.

Signs observed by parents or guardians:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes
- Can't recall events prior to hit or fall
- Can't recall events after hit or fall

Information on concussions provided by the Centers for Disease Control and Prevention.
For more information visit: **www.cdc.gov/Concussion**

IT'S BETTER TO MISS ONE CONTEST THAN THE WHOLE SEASON.

IMPORTANT: Students participating in interscholastic athletics, cheerleading and dance; and their parents/guardians; must sign the acknowledgement below and return it to their school. Students cannot practice or compete in those activities until this form is signed and returned.

We have received the information provided on the concussion fact sheet titled, **"HEADS UP: Concussion in High School Sports."**

Student's Signature	Date	Student's Printed Name
Parent's/Guardian's Signature	Date	Student's School