

**SIoux FALLS PUBLIC SCHOOL DISTRICT 49-5  
2010-11 ACTIVITIES PARTICIPANT PACKET**

**ATTENTION:** PARENTS/LEGAL GUARDIANS AND ACTIVITY PARTICIPANTS

**WARNING AND SAFETY STATEMENT**

Although participation in supervised interscholastic athletics and activities may be one of the least hazardous any student will engage in; by its nature, participation in interscholastic activities includes a risk of injury which may range in severity from minor to catastrophic injuries, including permanent paralysis or death. Serious injuries are not common in supervised school activity programs; however, it is possible only to minimize, not eliminate this risk.

**MEDICAL INSURANCE**

All students participating in interscholastic activities are required to have medical insurance. (**Please check the appropriate line below**).

- We do have family medical insurance (***or Medicaid***).
- We do **not** have family medical insurance & wish to purchase the basic family medical policy.

***Schools have insurance applications for school-time and full-time coverages.***

**YEAR-ROUND ACTIVITY RULES**

We have read the Sioux Falls School District year-round Activity Rules (Board Policy JJAA-R) and agree to abide by its rules and regulations.

**SDHSAA IN-SEASON RULE**

A student who is a member of a high school team may not participate in **games, practice, tryouts** in that particular sport during the same season on an independent or non-high school team or as a member of an "All Star" team. Violation of this rule causes the student to become ineligible for the high school team for the remainder of that sport season.

By signing below, we acknowledge that we agree to all of the above statements and rules, as well as the Consent for Release of Medical Information (HIPPA), and Consent for Medical Treatment.

Student Name \_\_\_\_\_ School ID # \_\_\_\_\_ Grade (fall 2010) \_\_\_\_\_

Students DOB \_\_\_\_\_ Address \_\_\_\_\_ Zip \_\_\_\_\_

Parent/Legal Guardian Name \_\_\_\_\_ Phone # \_\_\_\_\_

**SIGNED** \_\_\_\_\_ **SCHOOL** \_\_\_\_\_  
(Student)

**SIGNED** \_\_\_\_\_ **DATE** \_\_\_\_\_  
(Parent/Legal Guardian)

**Please complete ALL pages of this packet and sign where indicated.**

# SIOUX FALLS SCHOOL DISTRICT 49-5 PREPARTICIPATION HEALTH HISTORY

**PARENT/GUARDIAN must complete this form before the physical evaluation will be given.**

Name \_\_\_\_\_ Gender: F \_\_\_ M \_\_\_ School \_\_\_\_\_

Student ID # \_\_\_\_\_ DOB \_\_\_\_\_ Grade (Fall 2010) \_\_\_\_\_

Sioux Falls School District 49-5 requires all students who plan to participate in interscholastic activities to have on file in their school a record of satisfactory medical history and physical evaluation performed by a duly licensed Health Care Provider. This form must be completed by the PARENT or GUARDIAN and all "Yes" answers must be explained in the space below.

<b>HAS THE STUDENT ATHLETE:</b>	YES	NO		YES	NO
1. Has a doctor ever denied or restricted your participation in sports for any reason?	___	___	28. Have you had infectious mononucleosis (mono) within the last month?	___	___
2. Do you have an ongoing medical condition (like diabetes or asthma)?	___	___	29. Do you have any rashes, pressure sores, or other skin problems?	___	___
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	___	___	30. Have you had a herpes skin infection?	___	___
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	___	___	31. Have you ever had a head injury or concussion?	___	___
5. Have you ever passed out or nearly passed out DURING exercise?	___	___	32. Have you been hit in the head and been confused or lost your memory?	___	___
6. Have you ever passed out or nearly passed out AFTER exercise?	___	___	33. Have you ever had a seizure?	___	___
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	___	___	34. Do you have headaches with exercise?	___	___
8. Does your heart race or skip beats during exercise?	___	___	35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	___	___
9. Has a doctor ever told you that you have a heart murmur, high blood pressure, high cholesterol, or a heart infection?	___	___	36. Have you ever been unable to move your arms or legs after being hit or falling?	___	___
10. Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)	___	___	37. When exercising in the heat, do you have severe muscle cramps or become ill?	___	___
11. Has anyone in your family died for no apparent reason?	___	___	38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	___	___
12. Does anyone in your family have a heart problem?	___	___	39. Have you had any problems with your eyes or vision?	___	___
13. Has any family member or relative died of heart problems or of sudden death before age 50?	___	___	40. Do you wear glasses or contact lenses?	___	___
14. Does anyone in your family have Marfan syndrome?	___	___	41. Do you wear protective eyewear, such as goggles or a face shield?	___	___
15. Have you ever spent the night in a hospital?	___	___	42. Are you unhappy with your weight?	___	___
16. Have you ever had surgery?	___	___	43. Are you trying to gain or lose weight?	___	___
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game?	___	___	44. Has anyone recommended you change your weight or eating habits?	___	___
18. Have you had any broken or fractured bones or dislocated joints?	___	___	45. Do you limit or carefully control what you eat?	___	___
19. 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?	___	___	46. Do you have any concerns that you would like to discuss with a doctor?	___	___
20. Have you ever had a stress fracture?	___	___	<b>FEMALES ONLY</b>		
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	___	___	47. Have you ever had a menstrual period?	___	___
22. Do you regularly use a brace or assistive device?	___	___	48. How old were you when you had your first menstrual period? _____		
23. Has a doctor ever told you that you have asthma or allergies?	___	___	49. How many periods have you had in the last 12 months? _____		
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	___	___	<b>Explain "Yes" answers here:</b> _____		
25. Is there anyone in your family who has asthma?	___	___	_____		
26. Have you ever used an inhaler or taken asthma medicine?	___	___	_____		
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	___	___	_____		

To my best knowledge, everything is complete and correct. There are no other reasons not to qualify my child for activities. I give permission to the school or health care provider to complete a physical evaluation on my child named above.

DATE \_\_\_\_\_ **PARENT/GUARDIAN SIGNATURE** \_\_\_\_\_

If your son or daughter experiences pain or injury prior to, during or between activity seasons, please follow your physician's advice for care and inform the coach/director of the concern. Permanent injury often can be prevented by early recognition and appropriate precautions.

**SIoux FALLS SCHOOL DISTRICT 49-5  
PHYSICAL EVALUATION**

The HEALTHCARE PROVIDER must complete this form before student may participate in interscholastic activities. Please refer to Preparticipation Health History page for health history and parent permission.

Name \_\_\_\_\_ Gender: F \_\_\_ M \_\_\_ SCHOOL \_\_\_\_\_

Student ID # \_\_\_\_\_ DOB \_\_\_\_\_ Grade (Fall 2010) \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ / \_\_\_\_\_ Repeat in 5 minutes \_\_\_\_\_ / \_\_\_\_\_

Vision R - 20 / \_\_\_\_\_ L - 20 / \_\_\_\_\_ (Circle if) Glasses / Contacts

	Place one "X" per system when Hx questions reviewed and evaluation completed.	Describe Abnormal Findings on History or Evaluation.
<b><u>HEAD</u></b> PERR, No eyewear Hearing OK No dental appliances No oral piercing		
<b><u>MUSCULOSKELETAL</u></b> Neck, Back, Shoulders, Arms, Elbows, Forearms, Wrists, Hands, Hips, Thighs, Legs, Ankles, Feet		
<b><u>ABDOMEN</u></b> Appropriate body fat, Surgical Scars, Note organomegaly Males: scrotal testes, no hernia, no masses		
<b><u>CARDIOPULMONARY</u></b> Lungs clear, Heart: RRR no murmur		

**CLEARANCE**

\_\_\_\_\_ Cleared for ALL (*collision, contact/endurance, and other*)

\_\_\_\_\_ Cleared only for *contact/endurance* and *other*

\_\_\_\_\_ Cleared only for *other*

*"collision"* = football/wrestling;

*"contact/endurance"* = basketball/cross country/gymnastics/tennis/track/volleyball/baseball/softball/soccer/swimming;

*"other"* = golf/band/show choir/cheerleading/dance/bowling

\_\_\_\_\_ Above clearance to be granted only after \_\_\_\_\_

\_\_\_\_\_ Clearance cannot be given at this time because \_\_\_\_\_

\_\_\_\_\_ Further recommendations for parents / participant \_\_\_\_\_

Name of Examiner \_\_\_\_\_ Date \_\_\_\_\_

Note: The following licensed medical personnel are qualified to perform the evaluation and certify the health of the student participant:  
 Doctor of Medicine, Doctor of Osteopathy, Doctor of Chiropractic, licensed Physicians Assistant and licensed Nurse Practitioner.

**CONSENT FOR MEDICAL TREATMENT**

I am the mother / father / legal guardian of (student named below) who participates in co-curricular activities in the Sioux Falls Public School System. I hereby consent to any medical services & hospital care that may be required while said student is under the supervision of an employee of Sioux Falls School District while involved in a school-sponsored/approved activity. I hereby appoint said employee to act on my behalf in securing necessary medical services & hospital care from any duly licensed physician or osteopath.

**CONSENT OF STUDENT**  
I have read the above consent form signed by my mother / father / legal guardian, & join with him/her in consent.

**HEALTH HISTORY**

Student's Name: \_\_\_\_\_ ID #: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_  
 Student's Religion (optional): \_\_\_\_\_  
 Parent/Legal Guardian: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Insurance Company: \_\_\_\_\_ Insured Person: \_\_\_\_\_  
 Policy Number: \_\_\_\_\_  
 Father/Step-Father Work Phone: \_\_\_\_\_  
 Mother/Step-Mother Work Phone: \_\_\_\_\_  
 If we are unable to reach you in an emergency, whom should we contact?  
 Emergency Name: \_\_\_\_\_  
 Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Emergency Name: \_\_\_\_\_  
 Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Hospital Preference: \_\_\_\_\_  
 Phone: \_\_\_\_\_

**MEDICAL INFORMATION**

Family Doctor: \_\_\_\_\_ Date of Last Tetanus Shot: \_\_\_\_\_  
 Any Allergies: \_\_\_\_\_  
 Any Major Medical Problems (i.e. Heart, blood pressure, diabetes): \_\_\_\_\_  
 \_\_\_\_\_  
 Allergic to any Medications: \_\_\_\_\_  
 Medication Taken on a Daily Basis: \_\_\_\_\_

**Legal Representative's Signature:** \_\_\_\_\_

Circle one: **Parent** **Legal Guardian** **Other** \_\_\_\_\_

**Authorization for Release of Medical Information (HIPAA)**  
(Health Insurance Portability and Accountability Act)

**Student Name** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_

**Grade** \_\_\_\_\_ (Fall, 2010) **Gender** F  M

- I authorize the use or disclosure of the above named individual's health information including the Pre-Participation History and Physical Evaluation information pertaining to a student's ability to participate in school-sponsored/approved activities. Such disclosure may be made by a Health Care Provider generating or maintaining such information
- The information identified above may be used by or disclosed to the school nurse, athletic trainer, coaches, medical providers and other school personnel involved in the care of this student.
- This information for which I am authorizing disclosure will be used for the purpose of determining the student's eligibility to participate in co-curricular activities, any limitations on such participation and any treatment needs of the student.
- I understand that I have a right to revoke this authorization at any time by sending a written notice of revocation to the building Principal. I understand that the revocation will not apply to information that has already been released in reliance upon this authorization.
- This authorization will expire on: **6/30/2011**.
- I understand that once the above information is disclosed, the recipient may re-disclose it and federal privacy laws or regulations may not protect it and the information.
- I understand authorizing the use or disclosure of the information identified above is voluntary. However, a student's eligibility to participate in co-curricular activities depends on such authorization. I need not sign this form to ensure healthcare treatment.
- Notice: Organizations or persons who receive education records as defined by the Federal Educational Rights and Privacy Act (FERPA) may not provide access to such records to any other party without the written consent of the parent/guardian of the student.

\_\_\_\_\_ **Date**

**Legal Representative's Signature:** \_\_\_\_\_

Circle one: **Parent** **Legal Guardian** **Other** \_\_\_\_\_