

**SIoux FALLS PUBLIC SCHOOL DISTRICT 49-5
2011-12 ACTIVITY 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 (HIPAA), and Consent for Medical Treatment.

Student Name _____ School ID # _____ Grade (fall 2011) _____

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 Pre-participation 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 2011): _____

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.

		Yes	No
1.	Has a doctor ever denied or restricted your participation in sports for any reason?		
2.	Do you have an ongoing medical condition (like diabetes or asthma)?		
3.	Are you currently taking any prescription or non-prescription (over-the-counter) medicines or pills?		
4.	Do you have allergies to medicines, pollens, foods, or stinging insects?		
5.	Have you ever passed out or nearly passed out DURING exercise?		
6.	Have you ever passed out or nearly passed out AFTER exercise?		
7.	Have you ever had discomfort, pain, or pressure in your chest during exercise?		
8.	Does your heart race or skip beats during exercise?		
9.	Has a doctor ever told you that you have a heart murmur, high blood pressure, high cholesterol, or a heart infection?		
10.	Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)		
11.	Has anyone in your family died for no apparent reason?		
12.	Does anyone in your family have a heart problem?		
13.	Has any family member or relative died of heart problems or of sudden death before age 50?		
14.	Does anyone in your family have Marfan Syndrome?		
15.	Have you ever spent the night in a hospital?		
16.	Have you ever had surgery?		
17.	Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or game?		
18.	Have you had any broken or fractured bones or dislocated joints?		
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?		
20.	Have you ever had a stress fracture?		
21.	Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?		
22.	Do you regularly use a brace or assistive device?		
23.	Has a doctor ever told you that you have asthma or allergies?		
24.	Do you cough, wheeze, or have difficulty breathing during or after exercise?		
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?		

		Yes	No
28.	Have you had infectious mononucleosis (mono) within the last month?		
29.	Do you have any rashes, pressure sores, or other skin problems?		
30.	Have you had a herpes skin infection?		
31.	Have you ever had a head injury or concussion?		
32.	Have you been hit in the head and been confused or lost your memory?		
33.	Have you ever had a seizure?		
34.	Do you have headaches with exercise?		
35.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
36.	Have you ever been unable to move your arms or legs after being hit or falling?		
37.	When exercising in the heat, do you have severe muscle cramps or become ill?		
38.	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell anemia?		
39.	Have you had any problems with your eyes or vision?		
40.	Do you wear glasses or contact lenses?		
41.	Do you wear protective eyewear, such as goggles or a face shield?		
42.	Are you unhappy with your weight?		
43.	Are you trying to gain or lose weight?		
44.	Has anyone recommended you change your weight or eating habits?		
45.	Do you limit or carefully control what you eat?		
46.	Do you have any concerns that you would like to discuss with a doctor?		

Females only:

47.	Have you ever had a menstrual period?		
48.	How old were you when you had your first menstrual period?		
49.	How many periods have you had in the last 12 months?		

Explain "Yes" answers here: _____

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 Pre-participation Health History page for health history and parent permission.

Name: _____ Gender: F M School: _____
 Student ID #: _____ DOB: _____ Grade (Fall 2011): _____
 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.
Head PERR, No eyewear Hearing OK No dental appliances No oral piercing		
Musculoskeletal Neck, Back, Shoulders, Arms, Elbows, Forearms, Wrists, Hands, Hips, Thighs, Legs, Ankles, Feet		
Abdomen Appropriate body fat, Surgical Scars, Note organomegaly Males: scrotal testes, No hernia, no masses		
Cardiopulmonary 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/cheer/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: _____ 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: _____
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 _____

MEDICAL INFORMATION

Authorization for Release of Medical Information (HIPAA)

(Health Insurance Portability and Accountability Act)

Student Name _____

Date of Birth _____

Grade _____ (Fall, 2011) Gender F M

1. 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.
2. 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.
3. 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.
4. 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.
5. This authorization will expire on: **6/30/2012**.
6. 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.
7. 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.
8. 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 _____