CENTRAL DEWITT ACTIVITIES RELEASE FORM

STUDENT INFORMATION

Student Name: _____
Last First MI

Grade:_____ **Gender:** _____ **Birthdate:** _____ /_____ /_____

Student Address: _____

Home Phone: _____

Parents (or Legal Guardians): _____

Work place for Parents (or Legal Guardians): _____

Work phone for Parents (or Legal Guardians): _____

In case of emergency, when parents or legal guardians cannot be reached, please contact:

Name: _____ **Phone:** _____

Relationship: _____

Family Physician & phone: _____

Preferred Hospital & phone: _____

Family Dentist & phone: _____

ACTIVITY OPPORTUNITIES

Students are given the opportunity to participate in the following activities: Cross Country, Football, Volleyball, Basketball, Wrestling, Bowling, Golf, Track, Baseball, Softball, Cheerleading, Dance Team, Drama, Speech, Band & Vocal Music, Model UN, Academic Decathlon, IA Youth Symposium, FFA.

ACADEMIC REQUIREMENTS:

To participate in Central DeWitt School Activities, students must pass at least 20 credit hours (typically 4 academic subjects) the previous semester in accordance with the rules and regulations of the IHSAA, IGHSAU and Iowa Dept. of Education.

PHYSICIAN'S PERMIT

Every student participating in IHSAA and/or IGHSAU athletics, must have a valid physical on file with the Central DeWitt Athletic Dept. Office. Physicals are valid for 1 year (365 days) from the date of examination.

CONSENTS

•The Central DeWitt CSD does not purchase accident insurance to cover injuries incurred by your child at school. We encourage all families to have accident coverage on their children prior to participation in any sports or school-sponsored activity. If you need additional accident insurance please contact Central DeWitt HS or Central DeWitt MS office.
We the undersigned feel we have adequate insurance protection for our son/daughter while practicing or participating in interscholastic sports or other school-sponsored activities.

•Iowa law requires a parent's or legal guardian's written consent before their student can receive emergency treatment, unless in the opinion of a physician the treatment is necessary to prevent death or serious injury. As parents or legal guardians of the child named on this form we authorize emergency medical treatment or hospitalization that is necessary in the event of an accident or illness of our child. 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 a parent or guardian.

•We certify that we reviewed the information provided on the concussion fact sheet titled, "HEADS UP: Concussion in High School Sports" as found at: https://www.cd-csd.org/wp-content/uploads/2017/07/HEADS_UP_CONCUSSION_FACT_SHEET_053012.pdf

•We understand the eligibility regulations governing extracurricular activities at Central DeWitt Schools as found in the "Student-Parent Handbook for Athletic Participation" at: https://www.cd-csd.org/high-school/athletics/

***Signatures indicate I have read and understand the four consent areas.**

_____
Parent/Guardian signature Date

_____
Student signature Date

☐ Student has completed the pre-concussion testing.

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's Name: _____ M___ F___ Date of Birth _____ Grade _____

Home Address (Street, City, Zip) _____ School District _____

Parent's/Guardian's Name _____ Date _____ 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 this form on the right side bottom after the physical 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, 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?
18.	___	___	Heart problems (Racing, skipped beats, murmur, infection, etc.)?
19.	___	___	High blood pressure or high cholesterol?
20.	___	___	Head injury, concussion, unconsciousness?
21.	___	___	Headaches, 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 equip.?
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, 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: Tdap (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? Lose _____ Gain _____

FOR FEMALES ONLY:

1. How old were you when you had your first menstrual period? _____
2. How may periods have you had in the last 12 months? _____

PHYSICAL EXAMINATION RECORD (To be completed by a licensed medical professional as designated in Article VII 36.14 (1).

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 and Teeth			
5. Neck			
6. Lymph Nodes			
7. Heart (Standing & Lying)			
8. Pulses (esp. femoral)			
9. Chest & Lungs			
10. Abdomen			
11. Skin			
12. Genitals - Hernia			
13. Musculoskeletal – ROM, strength, etc. (see 24-31)			
14. Neurological			

Comments regarding abnormal findings: _____

_____

_____

LICENSED MEDICAL PROFESSIONAL'S ATHLETIC PARTICIPATION RECOMMEDATIONS

(Please be precise when indicating at which level the student is deared to participate.)

1. _____ **FULL & UNLIMITED PARTICIPATION**

2. _____ **LIMITED PARTICIPATION** - *May NOT participate in the following (checked):*
   ___ Baseball ___ Basketball ___ Bowling ___ Cross Country ___ Football ___ Golf ___ Soccer
   ___ Softball ___ Swimming ___ Tennis ___ Track ___ Volleyball ___ Wrestling

3. _____ **CLEARANCE PENDING DOCUMENTED FOLLOW UP OF** _____

4. _____ **NOT CLEARED FOR ATHLETIC PARTICIPATION DUE** _____

_____ _____

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 left 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/illness and to share necessary information about the injury/illness with appropriate school personnel.

_____ _____

Printed Name of Parent or Guardian, or student if 18 years of age **Signature of Parent or Guardian, or student if 18 years of age**

_____ _____

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. 08/15