# Insurance Statement

It is the policy of the Decorah Community Schools that students participating in inter-scholastic athletics either be covered by the group accident insurance plan or sign the enclosed statement that they do not wish coverage.

(The school is not forcing anyone to buy any insurance but only to sign a statement that they are aware of the group insurance plan).

_____ I do _____ I do not

wish to have _____ (Student's name) insured under the group

accident plan distributed through the school.

_____ _____

(Date) (Parent's Signature)

. . . . . .

# Acknowledgment of Risk

We realize there is a possibility that a player may suffer severe injury, including permanent paralysis or death, as a result of

participating in athletic activities.

_____ _____

PLAYER'S NAME - PRINT SCHOOL NAME

_____ _____

PLAYER'S SIGNATURE PARENT'S SIGNATURE

_____

DATE

**UPDATED AUGUST 2010**

# Decorah Community Schools

## Athletic Eligibility Packet

_____

(Student - Athlete's Name)

_____

(Grade)

_____

(School Year)

DIRECTIONS FOR COMPLETION:

1. Complete the above personal information blanks.
2. Schedule an appointment to enable a licensed professional to complete the designated section of the physical examinations forms.
3. Ensure that all of the required signatures listed below are in place.
4. Return the completed eligibility packet to the athletic offices.

REQUIRED SIGNATURES:

- Student - page 4
- Guardian - page 3 & 4
- Licensed Professional (Doctor) - page 3

**UPDATED AUGUST 2010**

# 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 _____ Male ___ Female ___ Date of Birth _____ Grade _____

Home Address _____ Phone # _____

Parent's/Guardian's Name _____ Date _____

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, 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. | ____ | ____ | 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: |
|---|---|---|---|
| 31. | ____ | ____ | Does anyone in your family have Marfan syndrome? |
| 32. | ____ | ____ | Has anyone in your family died of heart problems or any unexpected/unexplained reason before the age of 50? |
| 33. | ____ | ____ | Does anyone in your family have a heart problem, pacemaker or implanted defibrillator? |
| 34. | ____ | ____ | Has anyone in your family had unexplained fainting, seizures, or near drowning? |
| 35. | ____ | ____ | Does anyone your family have asthma? |

*Use this space to explain any **"YES"** answers from above (questions #1-35) or **to provide any additional information**:*

_____

_____

_____

34. Are you allergic to any prescription or over-the-counter medications? *If yes, list:* _____
35. List all medications you are presently taking (including asthma inhalers & EpiPens) and the condition the medication is for:
A. _____ B. _____ C. _____
36. Year of last known: Tetanus (lockjaw) vaccination: _____ Meningitis vaccination: _____
37. What is the most and least you have weighed in the past year? ***Most*** _____ ***Least*** _____
38. 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 many periods have you had in the last 12 months? _____



## *PHYSICAL EXAMINATION RECORD* (To be completed by a licensed medical professional as designated in Article VI 36.14(1). ***This evaluation is only to determine readiness for sports participation. It should NOT be used as a substitute fo 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 (esp. femoral) | | | |
| 9. Chest & Lungs | | | |
| 10. Abdomen | | | |
| 11. Skin | | | |
| 12. Genitals - Hernia | | | |
| 13. Musculoskeletal - ROM, strength, etc. *(See questions 23-27)* | | | |
| 14. Neurological | | | |

***Comments regarding abnormal findings:*** _____

_____

_____

## *LICENSED MEDICAL PROFESSIONAL'S ATHLETIC PARTICIPATION RECOMMENDATIONS*

_____ **FULL & 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 DOCUMENTED FOLLOW UP OF** _____

_____ **NOT CLEARED FOR ATHLETIC PARTICIPATION DUE TO** _____

_____ _____

**Licensed Medical Professional's Name** *(Printed)* **Date**

_____ _____

**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 of 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.* 7/10