INSURANCE STATEMENT

It is the policy of Decorah Community Schools that students participating in interscholastic athletics be covered by a private student accident insurance plan OR sign the statement below stating they do not wish to purchase coverage.

(The school district is not forcing anyone to purchase insurance but only to sign a statement that they are aware of the student accident insurance plan offering).

_____ I do _____ I do not

wish to have ______________________ insured under
(Student’s name)
the student accident plan offered by the school.

_________________________    __________________________
Date                        Parent Signature

ACKNOWLEDGEMENT 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.

_________________________    __________________________
Student’s Name (PRINT)        Parent/Guardian Name (PRINT)

_________________________    __________________________
Student’s Signature           Parent/Guardian Signature

_________________________    __________________________
Date                        School Name

DECORAH COMMUNITY SCHOOLS

ATHLETIC PHYSICAL
& ELIGIBILITY FORM

Directions for completion:
1. Parent and student fill out pages 1, 2, & 4 and sign where designated.
2. Schedule an appointment to enable a licensed professional to complete the top section of page 3.
3. Parent must sign the bottom of page 3 after the physical is complete from the licensed professional.

To have full eligibility, all sections of this form and all signatures must be completed.
IOWA ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION

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

Student’s Name ___________________________ Male □ Female □ Date of Birth ___________ Grade ___________

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

Parent’s/Guardian’s Name ___________________________ Date ___________ Phone # ___________________________

Family Physician ___________________________ Date ___________ 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).

Does this student have any current medications? Yes □ No □

Yes No Does this student have any previous medications? Yes □ No □

1. Allergies to medication, pollen, stinging insects, foods, etc.? 20. Head injury, concussion, unconsciousness?
2. Any illness lasting more than one (1) week? 21. Headache, memory loss, or confusion with contact?
3. Asthma or difficulty breathing during exercise? 22. Numbness, tingling or weakness in arms or legs with contact?
4. Chronic recurrent illness or injury? 23. Severe muscle cramps or illness when exercising in the heat?
5. Diabetes? 24. Fracture, stress fracture or dislocated joint(s)?
6. Epididymitis or other illnesses? 25. Injuries requiring medical treatment?
7. Syphilis or contact? 26. Knee injury or surgery?
8. Nerves or Malaria? 27. Neck injury?
9. Hospitalizations (overnight or longer)? 28. Orthotics, braces, protective equipment?
10. Marfan Syndrome? 29. Other serious joint injury?
11. Missing organ (eye, kidney, testicle)? 30. Punchable bursa or hernia in the groin area?
12. Mononucleosis or Rheumatic Fever? 31. X-rays, MRI, CT scan, physical therapy?
13. Seizures or frequent headaches? 32. Has a doctor ever denied or restricted your participation in sports for any reason?
14. Surgery? 33. Do you have any concerns you would like to discuss with your health care provider?

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

Athlete Name: ___________________________ Height: ___________ Weight: ___________

Pulse: ___________ Blood pressure: ___________/ ___________ (repeat, if abnormal) ___________/ ___________

Vision: R 20/____, L 20/____

NORMAL ABNORMAL FINDINGS INITIALS

1. Appearance (e.g. Marfan) ___________________________ 11. Eyebrows, eyelashes
2. Ears, Nose, Throat ___________________________ 12. Heart: Systolic, Diastolic
3. Pupil size (Equal/Unequal) ___________________________ 13. Precordialounds, plus: (e.g.奔)
4. Mouth & Teeth ___________________________ 14. Neurological
5. Neck ___________________________ 15. motor
7. Heart (Standing & Lying) ___________________________ 17. Fundus
8. Pulses (Brachial, Femoral) ___________________________ 18. Cardiac
10. Abdomen ___________________________ 20. Vascular
11. Skin ___________________________ 21. Neurological
13. Musculoskeletal—RSM: Strength, etc. (See questions 24-31) 23. Ophthalmological

Comments regarding abnormal findings:

LICENSED MEDICAL PROFESSIONAL’S ATHLETIC PARTICIPATION RECOMMENDATIONS
(please be precise when indicating at which level the student is cleared to participate.)

1. FULL & UNLIMITED PARTICIPATION

2. LIMITED PARTICIPATION—May NOT participate in the following (checked):

  Golf

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

Name of Parent or Guardian, or student if 18 years of age (Printed) ___________________________

Signature of Parent or Guardian, or student if age 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 Associations, 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. 10/19

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? ___________

Page 1 of 2, Physical Examination Record & Parent’s/Guardian’s Permission and Release is on the reverse side.