Dubuque COMMUNITY SCHOOLS

ATHLETIC PARTICIPATION REQUIRED FORMS

STUDENT INFORMATION

STUDENT NAME:		AGE:	GRADE:	DATE OF BIRTH (mm/dd/yyyy):
ADDRESS:		CITY:		ZIP:
HOME PHONE:	CELL PHONE:	EMAIL:		

PARENT / GUARDIAN INFORMATION

PARENT / GUARDIAN NAME:		EMPLOYER:
HOME PHONE:	CELL PHONE:	EMAIL:
PARENT / GUARDIAN NAME:		EMPLOYER:
HOME PHONE:	CELL PHONE:	EMAIL:

In an emergency, when parents (or legal guardians) cannot be notified, please contact:

NAME:	RELATIONSHIP:	CELL PHONE:

ACADEMIC REQUIREMENTS

Dubuque Community School District will follow the IHSAA/IGHSAU guidelines for academic eligibility. The Iowa Department of Education guidelines requires students to pass ALL subjects at the end of each grading period (semester grades). If a student has failed one or more subjects, a period of ineligibility will be assessed. Middle school students will follow District Policy 5305 academic eligibility.

DOCTOR'S PERMIT - PHYSICAL EXAMINATION

Every student participating in IHSAA and/or IGHSAU athletics, must have a valid physical on file with their school's Activities Office. Physicals are valid for one year (365 days) from the date of examination.

FAMILY PHYSICIAN:		PHONE:
PREFERRED HOSPITAL:		PHONE:
FAMILY DENTIST:		PHONE:
DO YOU WEAR: glasses [ ] YES [ ] NO	contacts [ ] YES [ ] NO	dentures [ ] YES [ ] NO

DATE OF LAST TETANUS BOOSTER:

LIST ANY KNOWN ALLERGIES, DRUG REACTIONS, OR OTHER PERTINENT MEDICAL INFORMATION:

CONSENT FOR MEDICAL TREATMENT

Iowa law requires a parent's, or legal guardian's, written consent before their son or daughter can receive emergency treatment, unless, in the opinion of a physician, the treatment is necessary to prevent death or serious injury.

As the parent(s), or legal guardian(s), of the child named on this form, I (we) authorize emergency medical treatment or hospitalization that is necessary in the event of an accident or illness of my (our) child. I (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 me (us).

PARENT / GUARDIAN SIGNATURE

DATE

DCSD SCHOOL BOARD POLICY #5305 PARTICIPATION CODE FOR ACTIVITIES

www.dbqschools.org/schoolboard/policies

By affixing my signature to this form, I affirm that I have read the Participation Code for Activities. I understand all the rules governing participation in the Dubuque Community School District activities programs and I agree to abide by those rules.

STUDENT SIGNATURE

PARENT / GUARDIAN SIGNATURE

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 (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 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?

****

	Yes	No	
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?

	Yes	No	*Does this student have / ever had?*
20.	_____	_____	Head injury, concussion, unconsciousness?
21.	_____	_____	Headache, memory loss, or confusion with contact?
22.	_____	_____	Numbness, tingling or weakness in arms or legs with contact?

****

	Yes	No	
23.	_____	_____	Severe muscle cramps or illness when exercising in the heat?

****

	Yes	No	
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?

****

	Yes	No	
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: 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 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 VII 36.14(1). ***This evaluation is only to determine readiness for sports participation. It should NOT be used as a substitute for 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 24-31)*			
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 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 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

A FACT SHEET FOR PARENTS AND STUDENTS

HEADS UP: Concussion in High School Sports

The Iowa Legislature passed a new law, effective July 1, 2011, regarding students in grades 7 – 12 who participate in extracurricular interscholastic activities. Please note this important information from Iowa Code Section 280.13C, Brain Injury Policies:

(1) A child must be immediately removed from participation (practice or competition) if his/her coach or a contest official observes signs, symptoms, or behaviors consistent with a concussion or brain injury in an extracurricular interscholastic activity.
(2) A child may not participate again until a licensed health care provider trained in the evaluation and management of concussions and other brain injuries has evaluated him/her and the student has received written clearance from that person to return to participation.
(3) Key definitions:
"Licensed health care provider" means a physician, physician assistant, chiropractor, advanced registered nurse practitioner, nurse, physical therapist, or athletic trainer licensed by a board.
"Extracurricular interscholastic activity" means any extracurricular interscholastic activity, contest, or practice, including sports, dance, or cheerleading.

What is a concussion?
A concussion is a brain injury. Concussions are caused by a bump, blow, or jolt to the head or body. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

What parents/guardians should do if they think their child has a concussion?
1. **OBEY THE NEW LAW.**
   a. Keep your child out of participation until s/he is cleared to return by a licensed healthcare provider.
   b. Seek medical attention right away.
2. Teach your child that it's not smart to play with a concussion.
3. Tell all of your child's coaches and the student's school nurse about ANY concussion.

What are the signs and symptoms of a concussion?
You cannot see a concussion. Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days after the injury. If your teen reports one or more symptoms of concussion listed below, or if you notice the symptoms yourself, keep your teen out of play and seek medical attention right away.

STUDENTS:
If you think you have a concussion:
- **Tell your coaches & parents –** Never ignore a bump or blow to the head, even if you feel fine. Also, tell your coach if you think one of your teammates might have a concussion.
- **Get a medical check-up –** A physician or other licensed health care provider can tell you if you have a concussion, and when it is OK to return to play.
- **Give yourself time to heal –** If you have a concussion, your brain needs time to heal. While your brain is healing, you are much more likely to have another concussion. It is important to rest and not return to play until you get the OK from your health care professional.

IT'S BETTER TO MISS ONE CONTEST THAN THE WHOLE SEASON.

Signs Reported by Students:
- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Just not "feeling right" or is "feeling down"

PARENTS:
How can you help your child prevent a concussion?
Every sport is different, but there are steps your children can take to protect themselves from concussion and other injuries.
- Make sure they wear the right protective equipment for their activity. It should fit properly, be well maintained, and be worn consistently and correctly.
- Ensure that they follow their coaches' rules for safety and the rules of the sport.
- Encourage them to practice good sportsmanship at all times.

Signs Observed by Parents or Guardians:
- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes
- Can't recall events prior to hit or fall
- Can't recall events after hit or fall

Information on concussions provided by the Centers for Disease Control and Prevention.
For more information visit: **www.cdc.gov/Concussion**

IMPORTANT: Students participating in interscholastic athletics, cheerleading and dance; and their parents/guardians; must sign the acknowledgement below and return it to their school. Students cannot practice or compete in those activities until this form is signed and returned.

We have received the information provided on the concussion fact sheet titled, "HEADS UP: Concussion in High School Sports."

Student's Signature	Date	Student's Printed Name
Parent's/Guardian's Signature	Date	Student's School