# 2018-19 Sioux Falls Public Schools "*Initial / Triennial*" Athletic Participant Packet

**ATTENTION**: PARENTS/LEGAL GUARDIANS/ATHLETIC PARTICIPANTS

**WARNING AND SAFETY STATEMENT**
Although participation in supervised interscholastic athletics may be one of the least hazardous any student will engage in, by its nature participation in interscholastic athletics 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 athletic programs; however, it is possible only to minimize, not eliminate this risk.

**MEDICAL INSURANCE**
It is the responsibility of the parent/guardian to provide adequate insurance to cover any medical expenses that may be incurred while a student is participating in a school-sponsored activity.

***Schools have insurance applications for school-time and full-time coverage.***

**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 | OUT-OF-SEASON RULE**
A student who is a member of a **high school team** is subject to all SDHSAA Rules. A copy of the IN-SEASON | OUT-OF-SEASON Rules may be found at http://www.sdhsaa.com/Athletics.aspx.

**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 2018) _____

_____ _____
Students DOB Address Zip

_____
Parent/Legal Guardian Name Phone #

**SIGNED** _____ **SCHOOL** _____
**(Student)**

**SIGNED** _____ **DATE** _____
**(Parent/Legal Guardian)**

**Please complete ALL forms in this packet and sign where indicated.**
***Packet MUST be completed and in School Athletic Office prior to start of first practice – including organized Summer Workouts.***

# SIOUX FALLS PUBLIC SCHOOLS PRE-PARTICIPATION MEDICAL HISTORY

Parent/Guardian must complete this form prior to your student participating in athletics.

NAME _____ GRADE _____ DATE OF BIRTH _____
(Fall 2018)

| | | 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:** _____

## AUTHORIZATION AND CERTIFICATION

As the parent/guardian, my signature (1) authorizes the above named student to participate in athletics and (2) certifies that to the best of my knowledge everything above is complete and correct and with full knowledge of above medical history that the above named student is physically fit to participate in interscholastic athletics for the 2018-19 school year.

_____ 20_____ _____
Date Signature of Parent

# Sioux Falls Public Schools Triennial Physical Evaluation

The HEALTHCARE PROVIDER must complete this form before student may participate in interscholastic high school athletics. Please refer to Pre-participation Health History page for health history and parent permission.

Name: _____ Gender: F ☐ M ☐ School: _____

Student ID #:_____ DOB: _____ Grade (Fall 2018): _____

1. Blood pressure (sitting) _____ / _____ Repeat in 5 minutes, if elevated _____ / _____.
2. Height _____
3. Weight _____

| | Normal | Abnormal | Comments |
|---|---|---|---|
| 4. Vision 20/_____ (L) 20/ _____ (R) | | | |
| 5. Head | | | |
| 6. Mouth (dentures, braces?) | | | |
| 7. Eyes (contacts?) | | | |
| 8. Chest/lung | | | |
| 9. Heart | | | |
| a. Heart sounds | | | |
| b. Murmurs | | | |
| c. Pulse (rad. vs fem.) | | | |
| d. Rhythm | | | |
| 10. Abdomen | | | |
| a. Liver or spleen | | | |
| b. Masses | | | |
| 11. Genitalia | | | |
| a. Hernias | | | |
| b. Testes | | | |
| 12. Orthopedic | | | |
| a. Cervical spine | | | |
| b. Shoulder shrug | | | |
| c. Deltoid | | | |
| d. Arms/elbow | | | |
| e. Hands | | | |
| f. Hips | | | |
| g. Knees | | | |
| h. Ankles | | | |
| i. Scoliosis | | | |

13. Tanner Maturation Index (Optional) Circle: I II III IV V

**SPORTS PARTICIPATION RECOMMENDED FOR:**

_____ All Sports: collision, contact/endurance, other

_____ Contact/Endurance Sports only due to _____

_____ Other Sports Only due to _____

_____ Sports Participation Not Recommended, due to _____

_____ Approval Withheld Pending evaluation for _____

**Definition**: [Collision=Football/Wrestling]; [Contact/Endurance Sports=Basketball, Cross Country, Gymnastics, Tennis, Track, Volleyball, Baseball, Softball, Soccer, Swimming, Competition Cheer and Competition Dance]; [Other Sports=Golf/Bowling]

**Name of Examiner:** _____ **Date:** _____
(Please Print)

**Signature of Examiner:** _____

**NOTE**: The following licensed medical personnel are qualified to perform the evaluation and certify the health of the student athlete: Doctor of Medicine, Doctor of Osteopathy, Doctor of Chiropractic, licensed Physicians Assistant and licensed Nurse Practitioner.

## Concussion Facts for Athletes

***What is a concussion?***

A concussion is a brain injury that:

- Is caused by a bump, blow, or jolt to the head or body
- Can change the way your brain normally works
- Can occur during practices or games in any sport or recreational activity
- Can happen even if you haven't been knocked out
- Can be serious even if you've just been "dinged" or "had your bell rung"

All concussions are serious. A concussion can affect your ability to do schoolwork and other activities (such as playing video games, working on a computer, studying, driving, or exercising). Most people with a concussion get better, but it is important to give your brain time to heal.

***What are the symptoms of a concussion?***

You can't see a concussion, but you might notice one or more of the symptoms listed below or that you "don't fell right" soon after, a few days after, or even weeks after the injury.

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Bothered by light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty paying attention
- Memory problems
- Confusion

***What should I do if I think I have a concussion?***

- Tell your coaches and your parents. Never ignore a bump or blow to the head even if you feel fine. Also, tell your coach right away if you think you have a concussion or if one of your teammates might have a concussion.
- Get a medical check-up. A doctor or other health care professional can tell if you have a concussion and when it is OK to return to play.
- Give yourself time to get better. If you have a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have another concussion. Repeat concussions can increase the time it takes for you to recover and may cause more damage to your brain. It is important to rest and not return to play until you get the OK from your health care professional that you are symptom-free.

***How can I prevent a concussion?***

Every sport is different, but there are steps you can take to protect yourself.

- Use the proper sports equipment, including personal protective equipment. In order for equipment to protect you, it must be:
  - The right equipment for the game, position, or activity
  - Worn correctly and the correct size and fit
  - Used every time you play or practice
- Follow your coach's rules for safety and the rules of the sport
- Practice good sportsmanship at all times

**It's better to miss one game than the whole season.**

Student Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

## Concussion Facts for Parents

***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 or what seems to be a mild bump or blow to the head can be serious.

***What are the signs and symptoms?***

You can't 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.

| Signs Observed By Parents or Guardians | Symptoms Reported by Athlete |
|---|---|
| • Appears dazed or stunned<br>• Is confused about assignment or position<br>• Forgets an instruction<br>• Is unsure of game, score, or opponent<br>• Moves clumsily<br>• Answers questions slowly<br>• Loses consciousness (even briefly)<br>• Shows mood, behavior, or personality changes<br>• Can't recall events prior to hit or fall<br>• Can't recall events after hit or fall | • Headache or "pressure" in head<br>• Nausea or vomiting<br>• Balance problems or dizziness<br>• Double or blurry vision<br>• Sensitivity to light or noise<br>• Feeling sluggish, hazy, foggy, or groggy<br>• Concentration or memory problems<br>• Confusion<br>• Just not "feeling right" or is "feeling down" |

***How can you help your teen prevent a concussion?***

Every sport is different, but there are steps your teens 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.

***What should you do if you think your teen has a concussion?***

1. **Keep your teen out of play.** If your teen has a concussion, her/his brain needs time to heal. Don't let your teen return to play the day of the injury and until a health care professional, experienced in evaluating for concussion, says your teen is symptom-free and it's OK to return to play. A repeat concussion that occurs before the brain recovers from the first - usually within a short period of time (hours, days, or weeks) - can slow recovery or increase the likelihood of having long-term problems. In rare cases, repeat concussions can result in edema (brain swelling), permanent brain damage, and even death.
2. **Seek medical attention right away**. A health care professional experienced in evaluating for concussion will be able to decide how serious the concussion is and when it is safe for your teen to return to sports.
3. **Teach your teen that it's not smart to play with a concussion. Rest is key after a concussion.** Sometimes athletes wrongly believe that it shows strength and courage to play injured. Discourage others from pressuring injured athletes to play. Don't let your teen convince you that s/he is "just fine".
4. **Tell all of your teen's coaches and the student's school nurse about ANY concussion.** Coaches, school nurses, and other school staff should know if your teen has ever had a concussion. Your teen may need to limit activities while s/he is recovering from a concussion. Things such as studying, driving, working on a computer, playing video games, or exercising may cause concussion symptoms to reappear or get worse. Talk to your health care professional, as well as your teen's coaches, school nurse, and teachers. If needed, they can help adjust your teen's school activities during her/his recovery.

Parent/Guardian Signature _____ Date _____

**<u>This form must be signed annually and must be available for inspection at the school</u>.**

## Medication Self-Administration for Students during Student Travel*

*As defined in JJH/JJH-R Student Travel & JLCD/JLCD-R Medication Administration

Medication: All prescribed medications, all over-the-counter (non-prescribed medications) and all chemical/homeopathic substances and compounds, including but not limited to natural remedies, herbs and vitamins*, which purport to aid in a person's health or well-being or to treat illness or disease.

Student Name: _____

Activity: _____

☐ My child will self-administer the following Medication(s) (name/dose/time):

_____

_____

☐ My child will not need to take medications during travel

I acknowledge that my student will be self-administering the above medication during his/her school activity outside of the school day. I understand that the school district and individuals involved will not be liable for the medication administration, lack thereof, or adverse effects of the medication. I understand that I am responsible for notifying the school and updating this form if there are new medications or updates to the medication listed above.

Parent Signature: _____

**If you do not feel your child is able to self-administer their medication, please contact your building Activity Director or School Nurse.**

Concussion form on the reverse side of this page.
Reminder that all forms must be signed and dated where indicated.

## CONSENT FOR MEDICAL TREATMENT

I am the mother / father / legal guardian of (student named below) who participates in 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 Schools 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 health care provider.

### HEALTH HISTORY

Student's Name: _____ ID #: _____

Address: _____

Phone Number: _____

Student's Religion (optional): _____

Parent/Legal Guardian: _____

Address: _____ 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: _____

### MEDICAL INFORMATION

Family Doctor: _____ Date of Last Tetanus Shot: _____

Any Allergies: _____

Any Major Medical Problems (i.e. Heart, blood pressure, diabetes):

_____

Allergic to any Medications: _____

**Legal Representative's Signature:** _____

**Circle one: Parent Legal Guardian Other:** _____

### CONSENT OF STUDENT

I have read the above consent form signed by my mother / father / legal guardian, & join with him/her in consent.

_____

**Student Signature**

## Authorization for Release of Medical Information (HIPAA)

(Health Insurance Portability and Accountability Act)

**Student Name** _____

**Date of Birth** _____

**Grade** _____ (Fall, 2018) **Gender** F ☐ M ☐

1. I authorize the use or disclosure of the above named individual's health information which may include 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 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: **6/30/2019**.
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 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

**Legal Representative's Signature:** _____ _____

**Date**

**Circle one: Parent Legal Guardian Other:** _____

_____ _____

**Student Signature** **Date**

(Note: Student signature is necessary if student will be 18 or older at any point during school year)