

2010 – 2011 ATHLETIC ELIGIBILITY FORM

****PLEASE -- PRINT ALL INFORMATION****

NAME _____ AGE _____ BIRTHDATE ____/____/____

ADDRESS _____ PHONE _____

BIRTHPLACE _____

CITY COUNTY STATE

PARENTS NAME: _____

FIRST AND LAST NAMES

SCHOOL ATTENDED LAST YEAR: _____

PRESENT YEAR IN SCHOOL (CIRCLE ONE): FRESHMAN SOPHOMORE JUNIOR SENIOR

NAME OF SPORT: FALL _____ WINTER _____ SPRING _____

Office Use Only: Physical Date - ____/____/____

SECTION I - RANDOM DRUG TESTING POLICY

I have read the Board of Education's Random Drug Testing Policy for student participants, and I understand the Board of Education's policy and the procedures. I agree to follow this policy and procedures, including drug testing as a condition of participation in co-curricular activities. I also give the drug testing facility permission to discuss all test results with the designated district official.

Signature of Student _____ Date _____

SECTION II - PERMISSION AND INSURANCE

I give my permission for my child _____ to participate in activities at Sterling High School for the school year 2010-2011.

Insurance coverage is required for participation in Sterling High School athletics.

Options for this coverage are:

____ 1. We have adequate coverage with the following:

Our insurance company is _____
(Company name is all that is required. We do NOT need policy #.)

____ 2. We want to purchase coverage for all activities EXCEPT football.

* Form will be available at Mandatory Parent Meetings
___ Coverage while at school or an activity ___ 24-hour coverage

____ 3. We want to purchase coverage for football ONLY.

* Form will be available at Mandatory Parent Meetings

____ 4. We want to purchase coverage for all activities INCLUDING football.

* Form will be available at Mandatory Parent Meetings
___ Coverage at school or an activity & Football coverage ___ 24-hour coverage & Football coverage

SECTION III – REFUND POLICY

I understand there is an \$80 fee (family cap of \$240) to participate on any Sterling High School interscholastic team. The fee must be paid before the student will be permitted to practice or try-out for a team. This payment is not refundable with the exception of being cut from the squad by the coach before the season begins. Any athlete that is a preseason cut from a team and still owes for books and other fees will have that \$80 applied to his/her account and will not receive a refund. Refunds will be returned by mail.

I have read Sections I and II and III agree to abide by them.

PRINTED NAME OF PARENT OR GUARDIAN _____

SIGNATURE OF PARENT OR GUARDIAN _____

DATE _____

SHS EMERGENCY TREATMENT MEDICAL CONSENT FOR ATHLETICS

Please print all information:

Athlete's LAST Name: _____ First Name: _____

Birth Date: ____ / ____ / ____ 2010-2011 Grade in School - (Circle one) 9 10 11 12

Permission is hereby granted to the attending physician to proceed with any minor surgical treatments, x-ray examination, and immunizations for the above named student in the event of serious illness or injury or the need for major surgery. I understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If said physician is not able to communicate with me, the treatment necessary for the best interest of the above named student may be given. Permission is also given for the athletic trainer and/or other school representatives to provide the needed emergency first aid treatment to the student prior to his/her admission to a medical facility.

Printed Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____

Date: ____ / ____ / ____

Parent's Home Phone: _____

Father's Cell Phone: _____

Work Phone: _____

Mother's Cell Phone: _____

Work Phone: _____

Physician's Name: _____

Physician's Phone: _____

Emergency contacts if unable to reach parents:

Name: _____

Phone: _____

Name: _____

Phone: _____

Does your Child have medical problems: (List):

Does your Child have allergies (List):

Does your Child take routine medications: (List)

Comments: _____

Sports your student intends to participate:

Fall: _____ Winter: _____ Spring: _____



Pre-participation Examination

To be completed by athlete or parent prior to examination.

Name _____ Last _____ First _____ Middle _____ Sport/Position _____

Social Security Number _____ School Year _____

Address _____ Phone No. _____

City/State _____ Student ID No. _____

Birthdate _____ Age _____ Class _____

Parent's Name _____

Address _____

Phone No. _____

Person to contact in case of emergency _____

Phone No. _____ City/State _____

Family Doctor _____

Phone No. _____

City/State _____

Yes No If yes, please explain (what where, when)

1. Presently taking medication (including birth control pills)?

2. Have you been diagnosed with asthma?

3. Have you been prescribed by a physician to use any asthma medication?

4. Do you have a current consent form to self-administer the asthma medication on file with your school?

5. Allergic to medicine, foods, bee stings?

6. Wears any appliances – glasses, contact lenses?

7. History of braces, chipped teeth, bridges?

8. Has ongoing medical problem?

9. Had serious or significant illness in past?

10. Any past surgical operations, accidents, non-sports or related injuries?

11. Any past injuries directly related to sports?

12. Any hospitalization not explained above?

13. Any known deformities (such as curvature of back, heart problems, one kidney, blindness in one eye, one testicle, etc.)?

14. Any serious family illness (such as diabetes, bleeding disorders, etc.)?

15. Family history of cancer?

16. Heart

Have you ever passed out during or after exercise?

Have you ever had chest pain during or after exercise?

Do you get tired more quickly than your friends do during exercise?

Have you ever had racing of your heart or skipped heartbeats?

If yes, please explain (what where, when)

17. Have you had high blood pressure or high cholesterol?

Have you ever been told you have a heart murmur?

Has any family member or relative died of heart problems or of sudden death before age 50?

Have you had a severe viral infection (for example myocarditis or mononucleosis) within the last month?

Has a physician ever denied or restricted your participation in sports for any heart problems?

Has anyone in your family had a heart attack before the age of 50?

18. Head and Nerve

Have you ever had a head injury or concussion?

Have you ever been knocked out, become unconscious, or lost your memory?

Have you ever had a seizure?

Do you have frequent or severe headaches?

Have you ever had numbness or tingling in your arms, hands, legs or feet?

Have you ever had a stinger, burner, or pinched nerve?

19. Last tetanus shot?

20. Last eye exam?

Last Menstrual period (if women)

Yes No

1. Smoking/smokeless tobacco

2. Alcohol/non-medical drugs: marijuana, cocaine, etc.

3. Steroids

4. Eating Disorders – weight loss or gain?

Review of systems (Please check if you have any problems with any of the following areas of your body)

Skin _____ Lungs _____ Shoulders, Arms,

Head _____ Heart _____ Hands

Eyes _____ Abdomen _____ Hips, Legs, Feet

Nose _____ Back _____ Muscle-Strength,

Mouth/Throat _____ Urination, _____ Feeling

Nutrition, _____ Bowel Control _____ Mental, Emotional

Weight Control _____ Genital (including _____ Fatigue

Neck _____ menstrual for women) _____ Other: What?

I certify that the above information is correct to the best of my knowledge.

Student Signature _____

Parent/Guardian Signature _____

Both Student and Parent/Guardian Signatures Are Mandatory

Physical Examination

Height _____ Weight _____ Blood Pressure _____

Pulse: resting _____ 15 hops _____ after 2 minutes resting _____

Visual Acuity: Eyes (R) 20/____ w/o glasses _____ (L) 20/____ w/glasses _____

Other Testing _____ Normal _____ Abnormal Findings _____

1. General _____
2. Skin _____
3. HEENT _____
4. Teeth (Dental Exam) _____
5. Neck _____
6. Lungs _____
7. Heart (Sit and Stand) _____
8. Abdomen _____
9. Genitalia _____
10. Musculoskeletal _____
- Neck _____
- Shoulder/Arm _____
- Elbow/Forearm _____
- Wrist/Hand _____
- Back _____
- Hip/Thigh _____
- Knee _____
- Shin/Calf _____
- Ankle/Leg _____
- Foot _____
11. Peripheral Pulses _____
12. Neurologic _____
13. Mental Status _____
14. Marfan Screen _____

Other Tests (optional) _____ U/V _____ EKG _____
 Auditory _____ Drug Screen _____ Chest X-Ray _____
 % Body Fat _____ SMAC _____ Tanner Stage _____
 Hgb/Hct _____

On the basis of the examination on this day, I approve this child's participation in interscholastic sports for one year.

Yes _____ No _____ Limited _____

Additional Comments:

Examination Date _____ Physician's Signature _____
 Physician's Assistant Signature* _____
 Advanced Nurse Practitioner's Signature* _____

*effective January 2003, the IHSA Board of Directors approved a recommendation, consistent with the Illinois School Code, that allows Physician's Assistants or Advanced Nurse Practitioners to sign off on physicals.

Student's Name _____ School Name _____

Consent Form to Self-Administer Asthma Medication

(not needed if current form is already on file with school)

Parent Consent

I, _____, do hereby give my son/daughter, _____, permission to self-administer his/her asthma medication as prescribed by his/her physician during athletic competition.

Parent's Signature _____ Date _____

Physician Consent

As a patient under my care, _____ is prescribed to self-administer the following asthma medication.

Medication _____

Purpose _____

Dosage _____

Time/Special Circumstances _____

Physician's Signature _____ Date _____

IHSA Steroid Testing Policy Consent to Random Testing

(This section for high school students only)

In January 2008, the Illinois High School Association's Board of Directors approved a plan developed by the IHSA's Sports Medicine Advisory Committee to implement random testing for steroids and performance-enhancing substances.

Beginning with the 2008-09 school term, any student-athlete who ingests or otherwise uses substance from the association's banned drug classes, without written permission by a licensed physician, to treat a medical condition, violates IHSA By-law 2.170 and its subsections, and is subject to IHSA penalties, including ineligibility from competition. The IHSA will test certain randomly selected individuals and teams that participate in state series competitions for banned substances. The results of all tests shall be considered confidential and shall only be disclosed to the student, his or her parents, and his or her school.

By signing below, we consent to random testing in accordance with the IHSA's steroid testing policy. We understand that, if the student or the student's team participates in state series competitions, the student may be subject to testing for banned substances.

No student-athlete may participate in IHSA state series competition unless the student and the student's parent/guardian consent to random testing.

A complete list of the current IHSA Banned Drug Classes can be accessed at http://www.ihsa.org/initiatives/sports/Medicine/files/IHSA_banned_drug_classes.pdf

Signature of student-athlete _____ Date _____
 Signature of parent-guardian _____ Date _____

