

2011 – 2012 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 2011-2012.

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 participate in the first scheduled contest. This payment is not refundable with the exception of being cut from the squad by the coach before the season begins or injury resulting in no play. Any athlete that is a preseason cut from a team or on injury reserve 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: ____ / ____ / ____ 2011-2012 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 _____ School Year _____
Last First Middle

Address _____ City/State _____

Phone No. _____ Birthdate _____ Age _____ Class _____ Student ID No. _____

Parent's Name _____ Phone No. _____

Address _____ City/State _____

HISTORY FORM

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies? Yes No If yes, please identify specific allergy below.
 Medicines Pollens Food Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	Yes	No
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Have you or any family member or relative been diagnosed with cancer?		
52. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY	Yes	No
53. Have you ever had a menstrual period?		
54. How old were you when you had your first menstrual period?		
55. How many periods have you had in the last 12 months?		

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____



Pre-participation Examination



PHYSICAL EXAMINATION FORM

EXAMINATION			
Height	Weight	<input type="checkbox"/> Male	<input type="checkbox"/> Female
BP	(/)	Pulse	Vision R 20/ L 20/ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS	
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)			
Eyes/ears/nose/throat • Pupils equal • Hearing			
Lymph nodes			
Heart ^a • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)			
Pulses • Simultaneous femoral and radial pulses			
Lungs			
Abdomen			
Genitourinary (males only) ^b			
Skin • HSV, lesions suggestive of MRSA, tinea corporis			
Neurologic ^c			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/Ankle			
Foot/toes			
Functional • Duck-walk, single leg hop			

^aConsider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

^bConsider GU exam if in private setting. Having third party present is recommended.

^cConsider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

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

Yes _____ No _____ Limited _____ Examination Date _____

Additional Comments:

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.

IHSA Steroid Testing Policy Consent to Random Testing

(This section for high school students only)
2011-2012 school term

As a prerequisite to participation in IHSA athletic activities, we agree that I/our student will not use performance-enhancing substances as defined in the IHSA Performance-Enhancing Substance Testing Program Protocol. We have reviewed the policy and understand that I/our student may be asked to submit to testing for the presence of performance-enhancing substances in my/his/her body either during IHSA state series events or during the school day, and I/our student do/does hereby agree to submit to such testing and analysis by a certified laboratory. We further understand and agree that the results of the performance-enhancing substance testing may be provided to certain individuals in my/our student's high school as specified in the IHSA Performance-Enhancing Substance Testing Program Protocol which is available on the IHSA website at [www.IHSA.org](http://www.ihsa.org). We understand and agree that the results of the performance-enhancing substance testing will be held confidential to the extent required by law. We understand that failure to provide accurate and truthful information could subject me/our student to penalties as determined by IHSA.

A complete list of the current IHSA Banned Substance Classes can be accessed at http://www.ihsa.org/initiatives/sportsMedicine/files/IHSA_banned_substance_classes.pdf

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