Carlisle Community Schools
Activities Department

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TO: Parents/Guardians of Students Interested in Interscholastic Activities
SUBJECT: Interscholastic Eligibility
DATE: February 2010

This packet is for all 7-12 students interested in participating in interscholastic sports at Carlisle Community Schools. This packet must be completed, signed by the physician, as well as the parent/guardian, and turned in to the Activities Office in Central Office before students may practice or participate in an athletic event or school sponsored activity.

This packet includes the following information:

1. Physical Form - Each year student athletes must have and pass a physical to participate in athletics throughout the school year. Physicals are good for one year and **must be on file** in the Activities Office. **<u>This year there will not be free physicals offered.</u>** *Physicals must be signed by both the physician and the parent in order to be considered complete. Forms may be completed and signed prior to the physical.

2. Insurance Waiver - Additional insurance information is available through the school. *We require that parents initial their insurance needs on the back page of this packet.

3. Medical Consent - Iowa law requires a parent's, or legal guardian's, written consent before their son or daughter can receive emergency treatment. *Please sign the release on the back page of this packet.

Again, before any student will be allowed to practice or participate in an athletic event, they must have their packet turned in to the Activities Office. These forms will not be accepted by coaches.

If you have any questions concerning these matters, please contact the Activities Office at 989-0552.

*An asterisk marks each area where parent signature is required.

It is the policy of the Carlisle Community School District to provide equal educational and employment opportunities, and not to illegally discriminate on the basis of the gender, race, national origin, religion, creed, age, marital status, or disability in its programs and activities. Questions or concerns should be addressed to the Affirmative Action Coordinators, Dr. Tom Lane, Superintendent (515) 989-3589 or Diana Whited, (515) 989-5309

Last Name: ______________ First Name: ______________ Grade: ____

Please check activities in which student will participate.

- ☐ Baseball
- ☐ Basketball - Boys
- ☐ Basketball - Girls
- ☐ Cheerleading
- ☐ Color Guard
- ☐ Cross Country - Boys
- ☐ Cross Country - Girls
- ☐ Football
- ☐ Golf - Boys
- ☐ Golf - Girls
- ☐ Soccer - Boys
- ☐ Soccer - Girls
- ☐ Softball
- ☐ Track - Boys
- ☐ Track - Girls
- ☐ Volleyball
- ☐ Wrestling

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 print this information)

Name ______________________________ Male ____ Female ______ Date of Birth ___________ Grade __________

Home Address ____ Phone # ________________________

Parent's/Guardian'sName ______________________________________ Date __________________________

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 the end of this form after the physical examination is completed.)*

	Yes	*No*	***Has this student had any?***
1.	______	______	Chronic or recurrent illness or injury?
2.	______	______	Any illness lasting more than one (1) week?
3.	______	______	Rheumatic fever, mononucleosis?
4.	______	______	Hospitalizations (Overnight or longer)?
5.	______	______	Surgery, other than tonsillectomy?
6.	______	______	Missing organs (eye, kidney, testicle)?
7.	______	______	Allergy to medications, insects, food?
8.	______	______	Seasonal allergies (hay fever)?
9.	______	______	Problems with heart, blood pressure, cholesterol?
10.	______	______	Racing of your heart or skipped heart beats?
11.	______	______	Chest pain with exercise?
12.	______	______	Frequent headaches, convulsions, dizziness, fainting?
13.	______	______	Dizziness or fainting with exercise?
14.	______	______	Concussion, unconsciousness, extremity numbness?
15.	______	______	Heat exhaustion, heat stroke, or other heat related problems?
16.	______	______	Asthma?
17.	______	______	Epilepsy or other seizures?
18.	______	______	Diabetes?
19.	______	______	Eyeglasses or contact lenses?
20.	______	______	Dental braces, bridges, plates?

	Yes	*No*	***Is there a history of?***
21.	______	______	Injuries requiring medical treatment?
22.	______	______	Neck injury?
23.	______	______	Knee injury?
24.	______	______	Knee surgery?
25.	______	______	Ankle injury?
26.	______	______	Broken bones (fractures)?
27.	______	______	Other serious joint injuries?
28.	______	______	Use of protective equipment or braces?

	Yes	*No*	***Further History:***
29.	______	______	Is there a history of family or genetic disease?
30.	______	______	Has any family member died suddenly at less than 40 years of age of causes other than an accident?
31.	______	______	Has any family member had a heart attack at less than 55 years of age?
32.	______	______	Are you uncomfortably short of breath after running 2 miles (2 times around a track) without stopping?
33.	______	______	List all medications you are presently taking, including asthma inhalers, and the condition the medication is for:

A.
B.
C.

34. What is the most and least you have weighed in the past year? Most ____________________Least ____________________

Date of last known tetanus (lockjaw) shot: ______________________________

FOR WOMEN ONLY:

1. How old were you when you had your first menstrual period? ____________________________________
2. In the past year, what is the longest time you have gone between menstrual periods? ______________________

Use this space to explain any of the above numbered YES answers or to provide additional information:

____

____

____

PHYSICAL EXAMINATION RECORD (To be completed by a licensed 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 _________ Vision R 20/______ L 20/_________

	Normal	Abnormal findings	Initials
1. Appearance (esp.Marfan's)			
2. Eyes/Ears/Nose/Throat			
3. Mouth & Teeth			
4. Neck			
4. Lymph Nodes			
6. Heart (standing & lying)			
7. Pulses (esp. femoral)			
8. Chest & Lungs			
9. Abdomen			
10. Skin			
11. Genitals - Hernia			
12. Musculoskeletal - ROM, strength, etc. (See questions 21 - 28)			
13. Neurological			

Comments regarding abnormal findings: ____

____

____

ATHLETIC PARTICIPATION RECOMMENDATIONS:

_______ **Full and Unlimited Participation**

_______ **Limited Participation—May NOT participate in the following (checked):**

_____ Baseball _____ Basketball _____ Cross Country _____ Football _____ Golf _____ Soccer

_____ Softball _____ Swimming _____ Tennis _____ Track _____ Volleyball _____ Wrestling

_______ **Clearance Pending** Documented Follow up of ____

_______ **NOT CLEARED FOR ATHLETIC PARTICIPATION**

____

Licensed Professional's Name (Printed) **Date**

____

Licensed Professional's Signature **Phone**

Parent's or Guardian's Permission and Release **(Sign after the physical examination has been completed.)**

I hereby 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, athletic trainer, or other qualified personnel to give first aid treatment to my son or daughter at an athletic event in case of injury.

____

*Typed or printed Name of Parent or Guardian *Signature of Parent of Guardian

____

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 Association, and Iowa Girls High School Athletic Union.
8/00

Carlisle Student Athletic Permit Form

Student First Name:	Middle:	Last Name:	Graduation Year:
Address:			Phone Number:
City:	State:	Zip:	Date Of Birth:
Parent/Guardian Name(s):			Home Phone #:
Address:			Work Phone #::
City:	State:	Zip:	Alternate #:
Is the student Insured:	YES / NO (*please circle*)		
Name of Insurance Company:			
Physician Name:			Phone:

Insurance Waiver:

*(*Please initial the appropriate number.)*

1. ________We, the undersigned, feel we have adequate insurance protection for our son/daughter while practicing or participating in Interscholastic Sports or other school sponsored activities.

2. ________I am interested in receiving information regarding Hawk-I insurance coverage. I do understand that my son or daughter must have insurance to participant in Interscholastic Sports or other school sponsored activities.

Medical Consent:

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's name on the top of this page, I (we) authorize emergency medical treatment or hospitalization that is necessary in the event of an accident or illness of my child. I (we) understand 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).

I (we) understand that accidents may occur in athletics even though normal acceptable safety precautions have been taken. My son/daughter has my permission to practice and compete in the interscholastic program.

______________________________ ______________________

*Parent/Guardian Signature Date