Last Name: _____ First Name: _____ Grade: _____

Please check activities in which student will participate.

- ☐ Baseball
- ☐ Basketball—Boys
- ☐ Basketball—Girls
- ☐ Bowling
- ☐ Cheerleading
- ☐ Color Guard
- ☐ Cross Country—Boys
- ☐ Cross County—Girls
- ☐ Dance
- ☐ Football
- ☐ Golf—Boys
- ☐ Golf—Girls
- ☐ Soccer—Boys
- ☐ Soccer—Girls
- ☐ Softball
- ☐ Swimming
- ☐ Track—Boys
- ☐ Track—Girls
- ☐ Volleyball
- ☐ Wrestling

Carlisle Community Schools
Activities Department

Darin Schreck, Activities Director
Email: darin.schreck@carlisle.k12.ia.us
Vicki Born, Activities Assistant
E-mail: vicki.born@carlisle.k12.ia.us
430 School St., Carlisle, Iowa 50047
Phone: 515-989-5391

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

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 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. *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 989-5391.

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

NON-DISCRIMINATION POLICY STATEMENT

Students, parents, employees and others doing business with or performing services for the Carlisle Community School District are hereby notified that this school district does not discriminate on the basis of race, color, age, religion, national origin, creed, gender, marital status, socioeconomic status, sexual orientation, gender identity or disability in admission or access to, or treatment in, its programs and activities. There is a grievance procedure for processing complaints of discrimination. If you have questions or a grievance related to the district's compliance with the regulations implementing Title VI, Title VII, Title IX, the Americans with Disabilities Act (ADA), § 504 or *Iowa Code* § 280.3, please contact the district's Equity Coordinator, Brandon Eighmy, Human Resource Director, 430 School Street, Carlisle, IA. 50047, (515)-989-3589, brandon.eighmy@carlisle.k12.ia.us.

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'sName _____ 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 the end of this form after the physical examination is completed.)

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?
**********		
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?
20._____	_____	Head injury, concussion, unconsciousness?
21._____	_____	Headache, memory loss, or confusion with contact?
22._____	_____	Numbness, tingling or weakness in arms or legs with contact?
**********		
23._____	_____	Severe muscle cramps or illness when exercising in the heat?
**********		
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?
**********		
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 any family member 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 #1-39) 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 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,			
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

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. Schools are encouraged NOT to change this form from its published format. Additional school forms can be attached to this form. *5/12*

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