

**STUDENT ACTIVITIES PROGRAM
NEWELL-FONDA
NEWELL, IA**

Dear Parent/Guardian/Student:

The attached form must be completed and on file in the respective school office BEFORE participation in the first practice or event can be permitted.

The purpose of the form is as follows:

1. To authorize the student to participate in the program.
2. To assure the school that the parent/guardian/student have read the policies governing the student activities program.
3. To acknowledge that there can be some hazards involved with participating in the activities program.
4. To verify the student is covered by insurance for those activities which require insurance coverage (athletics, cheerleading, and dance team).

We appreciate your completion of this form. If you have any questions concerning this form, please contact the school.

This form along with the physical examination form, concussion form, and consent for medical treatment card **MUST BE** on file in the office before a student may start practice.

Thank you,
Christopher Feldhans, High School Principal
Dick Jungers , PK-8 Principal

**NEWELL-FONDA
PARENT/STUDENT ACKNOWLEDGEMENT & RELEASE FORM
FOR STUDENT ACTIVITIES
GRADES: 7-12**

Parents/Guardians/Students: Please read carefully and complete.

This form **MUST** be completed and on file in the respective school office before participation in the first practice or event will be permitted. In athletics along with cheerleading and dance team a completed and current physical examination must also be on file.

Students Name: _____ Grade: _____ School Year: _____

1. I/We hereby give my/our consent for the above student to participate in the students activities programs of Newell-Fonda.
2. I/We have read the policies state in the Student Activities Code and understand them fully. I/We agree that my/our son/daughter will abide by these policies while he/se is involved in the activity covered in the code, and are aware of the consequences for any violation of the policies.
3. I/We give my/our permission for the aboved named student to participate in activities programs, realizing that such activities involves the potential for injury which is inherent in all activities. I/We acknowledge that even with the best coaching/sponsoring the use of the most advanced protective equipment and strict observance of rules, injuries are still possible. On rare occasion these injuries can be so severe as to result in total disability, paralysis, or even death. I/We acknowledge that I/We have read and acknowledge this warning.

Parent(s)/Guardian(s) Signature: _____ Date: _____

4. **INSURANCE:** ALL participants in athletics, cheerleading, and dance team must have some type of family health/accident insurance coverage or must purchase an alternate policy.

___My/Our child is covered by a family health/accident insurance plan.

I/We will purchase the alternate insurance policy available through the school. (This may be purchased in addition to family coverage)

I/We understand that the school **DOES NOT** carry insurance to cover medical expenses incurred while participating and I/We will assume all such expenses personally. (Note: Examine your insurance policy carefully to make sure they cover interscholastic athletic participation).

Parent(s)/Guardian(s) Signature: _____ Date: _____

STUDENTS: Please read carefully.

I have received a copy of the Students Activity Code and have read the policies governing the activities program and understand them. I will abide by the policies while I am involved in the activities at Newell-Fonda, and am aware of the consequences for violating the policy.

By my participating in the organized activities, I realize that such activity involves the potential for injury which is inherent in all activities. I acknowledge that even with the best coaching/sponsoring use the most advanced protective equipment and strict observance of the rules, injuries are still a possibility. And on rare occasions these injuries can be so severe as to result in total disability, paralysis, or even death.

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, qualified doctor of chiropractic, licensed physician assistant, or advanced registered nurse practitioner, 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's Name _____ 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 on the other side of this form after the examination.)

- | | Yes | No | | Yes | No | |
|-------|------------|-----------|--|------------|-----------|--|
| 1. | _____ | _____ | Allergies to medication, pollen, stinging insects, food, etc.? | 20. | _____ | Head injury, concussion, unconsciousness? |
| 2. | _____ | _____ | Any illness lasting more than one (1) week? | 21. | _____ | Headache, memory loss, or confusion with contact? |
| 3. | _____ | _____ | Asthma or difficulty breathing during exercise? | 22. | _____ | Numbness, tingling or weakness in arms or legs with contact? |
| 4. | _____ | _____ | Chronic or recurrent illness or injury? | ***** | | |
| 5. | _____ | _____ | Diabetes? | 23. | _____ | Severe muscle cramps or illness when exercising in the heat? |
| 6. | _____ | _____ | Epilepsy or other seizures? | ***** | | |
| 7. | _____ | _____ | Eyeglasses or contacts? | 24. | _____ | Fracture, stress fracture or dislocated joint(s)? |
| 8. | _____ | _____ | Herpes or MRSA? | 25. | _____ | Injuries requiring medical treatment? |
| 9. | _____ | _____ | Hospitalizations (Overnight or longer)? | 26. | _____ | Knee injury or surgery? |
| 10. | _____ | _____ | Marfan Syndrome? | 27. | _____ | Neck injury? |
| 11. | _____ | _____ | Missing organ (eye, kidney, testicle)? | 28. | _____ | Orthotics, braces, protective equipment? |
| 12. | _____ | _____ | Mononucleosis or Rheumatic fever? | 29. | _____ | Other serious joint injury? |
| 13. | _____ | _____ | Seizures or frequent headaches? | 30. | _____ | Painful bulge or hernia in the groin area? |
| 14. | _____ | _____ | Surgery? | 31. | _____ | X-rays, MRI, CT scan, physical therapy? |
| ***** | | | | | | |
| 15. | _____ | _____ | Chest pressure, pain, or tightness with exercise? | 32. | _____ | Has a doctor ever denied or restricted your participation in sports for any reason? |
| 16. | _____ | _____ | Excessive shortness of breath with exercise? | 33. | _____ | Do you have any concerns you would like to discuss with your health care provider? |
| 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? | | | |

- | | Yes | No | |
|-----|------------|-----------|---|
| 34. | _____ | _____ | Does anyone in your family have Marfan syndrome? |
| 35. | _____ | _____ | Has anyone in your family 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 #1-38) 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: Tdap (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 medical professional as designated in Article VII 36.14(1).

Athlete's Name _____ Height _____ Weight _____

Pulse _____ Blood Pressure _____ / _____ (Repeat, if abnormal _____ / _____) Vision R 20/ _____ L 20/ _____

	<i>NORMAL</i>	<i>ABNORMAL FINDINGS</i>	<i>INITIALS</i>
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, strength, etc. (See questions 24-31)			
14. Neurological			

Comments regarding abnormal findings: _____

LICENSED MEDICAL PROFESSIONAL'S ATHLETIC PARTICIPATION RECOMMENDATIONS
(Please be precise when indicating at which level the student is cleared to participate.)

1. **FULL & UNLIMITED PARTICIPATION**
2. **LIMITED PARTICIPATION** - May **NOT** participate in the following (checked):
 Baseball Basketball Bowling Cross Country Football Golf Soccer
 Softball Swimming Tennis Track Volleyball Wrestling
3. **CLEARANCE PENDING DOCUMENTED FOLLOW UP OF** _____
4. **NOT CLEARED FOR ATHLETIC PARTICIPATION DUE** _____

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/illness and to share necessary information about the injury/illness with appropriate school personnel.

Name of Parent or Guardian, or student if 18 years of age (Printed) _____ Signature of Parent of Guardian, or student if 18 years of age _____

Address (Street/PO Box, City, State, Zip) _____ Phone Number _____

HEALTH AND INJURY INFORMATION CARD and CONSENT FOR MEDICAL TREATMENT FORM

(This form is to be completed and kept available for reference wherever competition takes place. Update medical information as necessary.)

Student's Name (Last, First, MI) _____

Age _____ Grade _____ Date of Birth _____ Today's Date _____

Parent's/Guardian's Name _____

Student's Address _____

Parent's/Guardian's Home Phone Number _____

Father's/Guardian's Place of Work _____

Father's/Guardian's Work Phone Number _____

Mother's/Guardian's Place of Work _____

Mother's/Guardian's Work Phone Number _____

In an emergency, when parent's/guardian's cannot be notified, please contact:

_____ Relationship _____ Phone _____

_____ Relationship _____ Phone _____

Family Physician _____ Phone _____

Preferred Hospital _____ Phone _____

Family Dentist _____ Phone _____

Date of last tetanus booster: _____ (month/year)

Do you wear: Glasses _____ yes _____ no / Contacts _____ yes _____ no / Dentures _____ yes _____ no

List any known allergies, drug reactions, or other pertinent medical information. (Diabetes, seizures, history of head injury with unconsciousness or confusion, medications, etc.)

Please note and date any new injury information here: _____

CONSENT FOR MEDICAL TREATMENT

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 named on the front of this card, I (we) authorize emergency medical treatment or hospitalization that is necessary in the event of an accident or illness of my (our) child. I (we) understand that 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).*

Date Parent's/Guardian's signature

Consent for Treatment endorsed by the Iowa Chapter of the American Academy of Emergency Physicians
Cards provided by THE IOWA HIGH SCHOOL ATHLETIC ASSOCIATION, BOONE, IA

HEADS UP: Concussion in High School Sports

Please note this important information based on Iowa Code Section 280.13C, Brain Injury Policies:

- (1) A student participating in extracurricular interscholastic activities, in grades seven through twelve, **must be immediately removed from participation** if the coach, contest official, licensed healthcare provider or emergency medical care provide believe the student has a concussion based on observed signs, symptoms, or behaviors.
- (2) Once removed from participation for a suspected concussion, the **student cannot return to participation until written medical clearance has been provided** by a licensed health care provider.
- (3) A student cannot return to participation until s/he is free from concussion symptoms at home and at school.
- (4) Definitions:
 - “**Contest official**” means a referee, umpire, judge, or other official in an athletic contest who is registered with the Iowa high school athletic association or the Iowa girls high school athletic union.
 - “**Licensed health care provider**” means a physician, physician assistant, chiropractor, advanced registered nurse practitioner, nurse, physical therapist, or athletic trainer licensed by a board.
 - “**Extracurricular interscholastic activity**” means any extracurricular interscholastic activity means any dance or cheerleading activity or extracurricular interscholastic activity, contest, or practice governed by the Iowa high school athletic association or the Iowa girls high school athletic union that is a contact or limited contact activity as identified by the American academy of pediatrics.
 - “**Medical clearance**” means written clearance from a licensed health care provider releasing the student following a concussion or other brain injury to return to or commence participation in any extracurricular interscholastic activity.

What is a concussion?

Concussions are a type of brain injury that disrupt the way the brain normally works. Concussions can occur in any sport or recreational activity and can result from a fall or from players colliding with each other, the ground, or obstacles. Concussions can occur with or without loss of consciousness, but most concussions occur without loss of consciousness.

What parents/guardians should do if they think their child has a concussion?

1. Teach your child that it's not smart to play with a concussion.
2. **OBEY THE LAW.**
 - a. Seek medical attention right away.
 - b. Keep your child out of participation until s/he is cleared to return by a licensed healthcare provider.
3. Tell all of your child's coaches, teachers, and school nurse about ANY concussion.

What are the signs and symptoms of concussion?

Signs and symptoms of concussion can show up right after the injury or may not be noticed until days after the injury. If an athlete reports one or more symptoms of concussion after a bump, blow, or jolt to the head or body, s/he should be removed from play immediately. The athlete should only return to play with permission from a health care provider and after s/he is symptom free at home and at school.

Signs Observed by Parents or Coaches:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes
- Can't recall events prior to hit or fall
- Can't recall events after hit or fall

Symptoms Reported by Student-Athlete:

- Headache or “pressure” in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light
- Sensitivity to noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Just not “feeling right” or is “feeling down”

STUDENTS, If you think you have a concussion:

- **Tell your coaches & parents** – Never ignore a bump or blow to the head, even if you feel fine. Also, tell your coach if you think one of your teammates might have a concussion.
- **Get a medical check-up** – A physician or other licensed health care provider can tell you if you have a concussion, and when it is OK to return to play.
- **Give yourself time to heal** – If you have a concussion, your brain needs time to heal. While your brain is healing, you are much more likely to have another concussion. It is important to rest and not return to play until you get the OK from your health care professional.

PARENTS/GUARDIANS, You can help your child prevent a concussion:

- 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.

For more information visit: www.cdc.gov/Concussion

IMPORTANT: Students (grades 7-12) participating in interscholastic athletics, cheerleading and dance; and their parents/guardians; must annually sign the acknowledgement below and return it to their school. Students cannot practice or compete in those activities until this form is signed and returned.

We have received the information provided on the concussion fact sheet titled, “HEADS UP: Concussion in High School Sports.”

Student's Signature

Date

Student's Printed Name

Parent's/Guardian's Signature

Date

Student's Grade

Student's School