2017-18 PWHS ATHLETIC PARTICIPATION REQUIRED FORMS

All athletes must have the following items on file in the Main Office prior to participating in their sport…

Student Name: ______________________________________

☐ Physical Evaluation Clearance Form

Or

☐ Alternate Year Physical Card

☐ Proof of Insurance or Insurance Waiver signed by parent/guardian

☐ Informed Consent

☐ WIAA Rules of Eligibility

☐ Activity Code Exam

☐ Concussion Form

☐ Participation Fee of $85 per each activity within two weeks of the starting date ($170 student maximum per year/$340 family maximum per year)

Documents are available in the high school office or online:
http://portwashingtonathletics.org/index.cfm?action=main.fileslinks

Return this sheet and all of the required forms in this packet before the first practice. Please do not hand in forms individually.

PREPARTICIPATION PHYSICAL EVALUATION
CLEARANCE FORM

WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION – ATHLETIC PERMIT CARD

(Print or Type)

ALL STUDENTS PARTICIPATING IN INTERSCHOLASTIC ATHLETICS MUST HAVE THIS CARD ON FILE AT THEIR SCHOOL PRIOR TO PRACTICE OR PARTICIPATION

Physical examination taken April 1 and thereafter is valid for the following two school years; physical examination taken before April 1 is valid only for the remainder of that school year and the following school year.

NAME (Last) ______ (First) ______ (Middle Initial) ______ Date of Birth ______

Age ______ Sex ______ Grade ______ School ______ City ______

Present Address ______ Telephone ______

❑ **Cleared without restriction** ❑ **Cleared, with the following qualifications:** ______

❑ **Not cleared** ❑ **Pending further evaluation** ❑ **For all sports** ❑ **For certain sports:** ______

Reason: ______

Recommendations: ______

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of Physician (Print/Type) ______

SIGNATURE OF LICENSED PHYSICIAN (MD OR DO)/PA/APNP*: ______

Clinic Name ______

Address/Clinic ______ City ______ State ______ Zip Code ______

Telephone ______ Date of Examination ______

* Physicians may authorize Nurse Practitioners to stamp this card with the physician's signature or the name of the clinic with which the physician is affiliated.

Parents' Place of Employment ______

Family Physician ______ Family Dentist ______

Name of Private Insurance Carrier ______ Telephone ______

Subscriber Member Name (Primary Insured) ______

Emergency Information

Allergies ______

Other Information (medication, etc.) ______

Immunizations ❑ **Up to date (see attached documentation)** ❑ **Not up to date - specify** ______

(e.g., tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis; pneumococcal; meningococcal; varicella)

1. I hereby give my permission for the above named student to practice and compete and represent the school in WIAA approved interscholastic sports except those restricted on this card.

2. Pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder (collectively known as "HIPAA"), I authorize health care providers of the student named above, including emergency medical personnel and other similarly trained professionals that may be attending an interscholastic event or practice, to disclose/exchange essential medical information regarding the injury and treatment of this student to appropriate school district personnel such as but not limited to: Principal, Athletic Director, Athletic Trainer, Team Physician, Team Coach, Administrative Assistant to the Athletic Director and/or other professional health care providers, for purposes of treatment, emergency care and injury record-keeping.

SIGNATURE OF PARENT/GUARDIAN ______ DATE ______

WIAA ALTERNATE YEAR ATHLETIC PERMIT/PHYSICAL CARD

SCHOOL YEAR 20__________ - 20__________

Physical Date _______________

NAME ____ GRADE ________________ DATE OF BIRTH ______________________
Last First Middle Initial

Present Address ____ Telephone ________________________________

Parents' Place of Employment ____

Family Physician ____ Family Dentist ____

Name of Private Insurance Carrier ____ Telephone ________________________________

Subscriber Member Name (Primary Insured) ____

1. I hereby give my permission for the above named student to practice and compete and represent the school in WIAA approved sports.
2. I also attest to the fact that the above named student has had no injury or illness serious enough to warrant a medical evaluation prior to participating this school year.
3. Pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder (collectively known as “HIPAA”), I authorize health care providers of the student named above, including emergency medical personnel and other similarly trained professionals that may be attending an interscholastic event or practice, to disclose/exchange essential medical information regarding the injury and treatment of this student to appropriate school district personnel such as but not limited to: Principal, Athletic Director, Athletic Trainer, Team Physician, Team Coach, Administrative Assistant to the Athletic Director and/or other professional health care providers, for purposes of treatment, emergency care and injury record-keeping.
4. It is recommended that information regarding your child’s allergies and prescribed medication be made available.

PARENT: If there is any question that this student may not be qualified for athletic competition without, at least, a partial re-evaluation, contact your medical advisor before signing card.

SIGNATURE OF PARENT ____ DATE ____

ALL STUDENTS PARTICIPATING IN INTERSCHOLASTIC ATHLETICS MUST HAVE THIS ALTERNATE YEAR CARD ON FILE AT THEIR SCHOOL PRIOR TO PRACTICE OR PARTICIPATION

2017-18 PORT WASHINGTON HIGH SCHOOL
Athletic Department

Dear Parents/Guardians:

The School District ***does not*** provide any type of health or accident insurance for injuries incurred by your child at school.

We encourage all families to have accident coverage on their children, prior to participation in any ***sports or school sponsored activity***. Please read the entire policy offering to determine if this program is a needed supplement to your own primary health insurance. If you feel your coverage is adequate, please sign the bottom of this letter and return to your coach or athletic director.

The options are:

			Annual Premium
A.	**Full-Time** (24 hour) - with No Sports	Grades K-12	$ 89.00
	Full-Time ($89.00) - with All Sports (except football, Grades 9-12)	Grades 7-12	$ 154.00
B.	**School-Time** - with No Sports	Grades K-12	$ 14.00
	School-Time - with All Sports (except football, Grades 9-12)	Grades 7-12	$ 79.00
C.	**Extended Dental Coverage**	Grades K-12	$ 8.00
D.	**Football ONLY Coverage** (football, Grades 7&8 are covered by the All Sports Coverage)	Grades 9-12	$ 185.00

In making application for coverage, please read brochures explaining options carefully.

1. Print name, address and other information clearly on the enrollment form.
2. Make check or money order payable to **STUDENT ASSURANCE SERVICES, INC.,** or complete the credit card payment form.
3. Print Student's name on the face of the check.
4. Detach and retain summary of coverage, and ***return the enrollment form to the school within 10 days***. Coverage will become effective at 12:01a.m. following the date the enrollment form and premium are received and dated by the school.
5. Questions about the plan may be directed to Student Assurance Services, Inc., at (651) 439-7098, or toll free 1-800-328-2739.

Please ***sign and return*** form below if you already have adequate insurance.

....

PARENTAL INSURANCE WAIVER

Student's Name: ____

Name of Insurance Company ____________________________ Company Phone ________________________________

Address of Insurance Company ____

We, the undersigned, feel we have adequate insurance protection for our Son/Daughter while practicing or participating in Interscholastic Sports.

Parent's/Guardian's Signature ____ Date _____________________

WIAA ELIGIBILITY BULLETIN

PARENT-ATHLETE WIAA RULES OF ELIGIBILITY
SIGN-OFF FORM

2017-18

I certify that I have read, understand, and agree to abide by all of the information contained in this WIAA bulletin. I further certify that if I have not understood any information contained in this document, I have sought and received an explanation of the information prior to signing this statement.

PORT WASHINGTON HIGH SCHOOL
School Name

______________________________ ______________________
Parent/Guardian's Signature Date

______________________________ ______________________
Student-Athlete's Signature Date

This form must be completed and submitted to the High School Office prior to a student being declared eligible to practice and compete.

PORT WASHINGTON HIGH SCHOOL
2017-18 INFORMED CONSENT

In order for the student to participate in extra-curricular activities he/she must comply with the code of conduct. When an athlete fails to comply with the terms of the athletic code, he/she cannot participate on the teams.

As parents or legal guardians, we are aware of the inherent risk of injury present in all sports and other activities. We realize that the risk may be severe, including serious physical injury and even death, which may occur during transportation to and from contests as well as the contest or practice itself. I/We acknowledge that even with proper supervision, the use of adequate protective equipment, and strict observance of rules, injuries are still a possibility.

I/We, as parents, have read the Port Washington High School Activities Code and the Informed Consent form. We understand the rules and regulations stated therein as well as the consequences should our child not abide by the Activities Code. I/We grant permission for our child to participate in the extra-curricular program at Port Washington High School.

____ ____________________

Parent/Legal Guardian Date

I have read the Port Washington High School Activities Code and the Informed Consent form and understand the information contained therein. I agree to abide by the rules and regulations stated therein and understand the penalties that I would be subject to if I do not adhere to those provisions.

____

Student Name-PLEASE PRINT

____ _____________________

Student Signature Date

Year of Graduation _________

2017-18 PARENT & ATHLETE
CONCUSSION & HEAD INJURY AGREEMENT

As a Parent and as an Athlete it is important to recognize the signs, symptoms, and behaviors of concussions. By signing this form, you are stating that you understand the importance of recognizing and responding to the signs, symptoms, and behaviors of a concussion or head injury. This form must be completed once a year for your child to be involved in athletic activities.

Parent Agreement:

I ________________________________ have read the Parent Concussion and Head Injury Information on the Port Washington High School Website and understand what a concussion is and how it may be caused. I also understand the common signs, symptoms, and behaviors. I agree that my child must be removed from practice/play if a concussion is suspected.

I understand that it is my responsibility to seek medical treatment if a suspected concussion is reported to me.

I understand that my child cannot return to practice/play until providing written clearance from an appropriate health care provider to his/her coach and trainer.

I understand the possible consequences of my child returning to practice/play too soon.

Parent/Guardian
Signature: ____ Date ____________

Athlete Agreement:

I ________________________________have read the Athlete Concussion and Head Injury Information and understand what a concussion is and how it may be caused.

I understand the importance of reporting a suspected concussion to my coaches, trainer, and my parents/guardian.

I understand that I must be removed from practice/play if a concussion is suspected. I understand that I must provide written clearance from an appropriate health care provider to my coach and trainer before returning to practice or play

I understand the possible consequences of returning to practice/play too soon and that my brain needs time to heal.

Athlete
Signature: ____ Date ____________

List ALL of the 2016-17 Athletic Activities that you intend to be involved in on the line below:

___

This form must be on file in the school office before the student may participate.