2020-21 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:

Grade: ____

Sports Participating in: _____

- o Physical Clearance Form—**turn into the office**
- o Alternate Year Physical I Card OR Alternate Extension Card (2020-21 School year only—**turn into the office**
- o **ONLINE**--Proof of Insurance or Insurance Waiver
- o **ONLINE**--Informed Consent
- o **ONLINE**--WIAA Rules of Eligibility
- o **TAKEN WITH THE TEAM**--Activity Code Exam
- o Athletic Trainer Required Forms—**turn into the office**
- o **ONLINE**--Concussion Form
- o Participation Fee of $85 per each activity
  ($170 student maximum per year/$340 family maximum per year) *DUE within 2 weeks Of the start date OR by the first competition whichever comes first*

Documents are available inthe high school office or online on the athletics website.

Return this sheet and all of the required forms in this packet before the start of practice to the main office. Please do not hand in forms individually.

Coaches are NOT allowed to collect paperwork.

PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY 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 assigned at birth (F, M or intersex) _____ Grade _____ School _____ City _____

Present Address _____ Telephone _____

❑ **Medically eligible for all sports without restriction**

❑ **Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of**

_____

_____

❑ **Medically eligible for certain sports**

_____

_____

❑ **Not medically eligible pending further evaluation**

❑ **Not medically eligible for any sports**

Recommendations: _____

_____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical exam findings are 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, the physician may rescind the medical eligiblity until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of health care professional (Print/Type) _____

SIGNATURE OF HEALTH CARE PROFESSIONAL (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 _____

Medications _____

Other Information _____

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 _____

ALTERNATE YEAR CARD ON FILE AT THEIR SCHOOL PRIOR TO PRACTICE OR PARTICIPATION

WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION ALTERNATE YEAR ATHLETIC PERMIT CARD

Physical Date _____ SCHOOL YEAR 20_____ - 20_____

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

HEALTH HISTORY UPDATE QUESTIONNAIRE

Name of School Port Washington High School--Alternate Year Physical Extension for 2020-21 School Year Only

To participate on a school-sponsored interscholastic athletic team or squad, a student whose physical examination was completed within the last two years, and whose local primary care physician is unable to provide a new physical, must submit this form to the school. This health history update questionnaire must be completed and signed by the student's parent or guardian.

Student _____ **Age**_____ **Grade** _____

Date of Last Physical Examination_____ **Sport**_____

Since the last pre-participation physical examination, has your son/daughter:

1. Had any changes in health since the last physical? Yes ___ No ___
2. Had a positive lab test for COVID-19 or been hospitalized with presumed COVID-19? Yes ___ No ___
3. Been medically advised not to participate in a sport? Yes____ No____

   If yes, describe in detail _____

   _____

   _____
4. Sustained a concussion, been unconscious or lost memory from a blow to the head? Yes____ No____

   If yes, explain in detail _____

   _____

   _____
5. Broken a bone or sprained/strained/dislocated any muscle or joints? Yes____ No____

   If yes, describe in detail _____

   _____

   _____
6. Fainted or "blacked out?" Yes____ No____

   If yes, was this during or immediately after exercise? _____

   _____

   _____
7. Experienced chest pains, shortness of breath or "racing heart?" Yes____ No____

   If yes, explain _____

   _____
8. Has there been a recent history of fatigue and unusual tiredness? Yes____ No____
9. Been hospitalized or visited the emergency room? Yes____ No____

   If yes, explain in detail _____

   _____

   _____
10. Since the last physical examination, has there been a sudden death in the family or has any member of the family under age 50 had a heart attack or "heart trouble?" Yes____ No____
11. Started or stopped taking any over-the-counter or prescribed medications that your primary care provider is not aware of? Yes____ No____

    If yes, name of medication(s)_____

    _____

Date: _____ **Signature of parent/guardian** _____

PLEASE RETURN COMPLETED FORM TO THE SCHOOL NURSE

Port Washington High School

Sports Medicine Emergency Information and Consent

Student's Name: _____ Date of Birth: _____
Parent/Guardian 1 Name: _____ Phone: _____
Address: _____
Parent/Guardian 2 Name: _____ Phone: _____
Address: _____
Alternate Emergency Contact Name: _____ Relationship: _____
Address: _____ Phone: _____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

First, Try:	☐ Parent/Guardian 1	☐ Parent/Guardian 2	☐ Alternate Emergency Contact
Then, Try:	☐ Parent/Guardian 1	☐ Parent/Guardian 2	☐ Alternate Emergency Contact
Then, Try:	☐ Parent/Guardian 1	☐ Parent/Guardian 2	☐ Alternate Emergency Contact

STUDENT'S MEDICAL INFORMATION

Primary Doctor: _____ Phone: _____
Current Medications: _____
Known Allergies: _____
Other Medical Conditions: (asthma, diabetes, previous head injuries, etc. Use back of sheet if needed) _____
_____
_____ ☐ (continued on back)
Name of Medical Insurance Company or Plan: _____
Policy Number: _____ Is plan an HMO? ☐ Yes ☐ No
If plan is an HMO, what is your primary care facility? _____

MEDICAL CONSENT TO TREAT STUDENT; AUTHORIZATION TO DISCLOSE STUDENT'S MEDICAL INFORMATION

Consent may be required in order for Student to participate in an athletic program. Consent is effective until it is revoked by a parent or guardian, or until Student is no longer enrolled at the School.
If no box is checked, it is assumed that consent is NOT given. Please check all applicable.

☐ **Yes** ☐ **No** The athletic staff, including athletic trainers, coaches, or other qualified personnel may apply first aid treatment for any injury sustained during participation in athletic programs sanctioned by School.

☐ **Yes** ☐ **No** The athletic trainer may evaluate and treat other emergent or non-emergent Student injuries or medical conditions brought to the athletic trainer's attention as they relate to the Student's physical activity, conditioning or injury prevention.

☐ **Yes** ☐ **No** If the athletic staff determines that Student is in need of immediate medical attention beyond that which can be provided by the athletic staff at School and the Student's parent, guardian, or emergency contact cannot be reached, the athletic staff may use their judgment in securing medical aid, including ambulance service and admittance to a hospital if needed.

☐ **Yes** ☐ **No** If available at School, School's athletic trainer may provide appropriate treatment modalities, such as ultrasound and electronic stimulations to treat any Student injury or other medical condition.

Parent/Guardian Signature: _____ Date: _____
☐ Parent 1 ☐ Parent 2 ☐ Guardian (relationship) _____

Student Signature: _____ Date: _____

Port Washington High School

AUTHORIZATION TO DISCLOSE STUDENT'S MEDICAL INFORMATION

If this document is not signed, it is assumed that authorization is **NOT** given. Authorization is effective until it is revoked by a parent or guardian, or until Student is no longer enrolled at the School.

Student's Name: _____ Date of Birth: _____

The purpose of this authorization is to permit disclosure of Student's protected health information (PHI) among health care professionals, coaches, athletic training staff, insurance personnel, and academic counselors and administrators. This disclosure allows athletic medical staff and School to make certain decisions about Student's health and ability to participate in certain athletic programs sanctioned by School in accordance with the Health Information Portability and Accountability Act (HIPAA). HIPAA protects personal injury and illness information from disclosure without authorization under HIPAA. Student's PHI includes, but is not limited to, information involving the nature and treatment of an injury or illness, medical history and status, prognosis, diagnosis, athletic participation status, insurance coverage, and copies of hospital and medical records.

Pursuant to this signed authorization, athletic training staff, including trainers, coaches, or other qualified personnel of Port Washington High School (School) are authorized to disclose Student's PHI verbally or in writing, as necessary and appropriate for the purpose of health care treatment or exchanging information regarding Student's health as permitted or required under the law (e.g. determining Student's ability and eligibility to participate in athletic programs sanctioned by School, evaluating injuries and other medical conditions which Student reports while engaging in athletic programs sanctioned by School, etc.).

The Student's PHI may be disclosed to:

(1) School's coaches, athletic director, or other members of School's administrative staff or their designees;
(2) Student's parents and guardians; and
(3) Emergency medical personnel, hospitals, or other health care professionals who evaluate, diagnose or treat an injury, illness, or other condition incurred by Student while participating in athletic programs sanctioned by School, as necessary to:
    (a) Evaluate Student's eligibility to participate in School activities, including but not limited to interscholastic or intramural sports programs and physical education classes;
    (b) Document and evaluate first aid treatment and athletic treatment modalities provided;
    (c) Evaluate treatment alternatives; and
    (d) Resolve disputes that arise with regard to the above.

Signing this authorization/consent is voluntary, and authorization may be revoked at any time by a written revocation sent to both School's athletic department and athletic training staff. However, authorization may be required in order for Student to participate in an athletic program. Any revocation will not apply to information that has already been released. Student and Student's parents and guardians reserve the right to review all records and to obtain a copy of all records released at any time upon request. In the event that Student's PHI is re-disclosed by a person who receives it under this authorization, it will no longer be covered by this authorization.

Parent Signature: _____ Date: _____
Parent Name: _____

Student Signature: _____ Date: _____