

2021-22 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: _____

Physical Evaluation Clearance Form

Or

Alternate Year Physical Card

ONLINE--Proof of Insurance or Insurance Waiver signed by parent/guardian

ONLINE--Informed Consent

ONLINE--WIAA Rules of Eligibility

Activity Code Exam

Athletic Trainer Required Forms

ONLINE--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) ***DUE within 2 weeks of start date OR by the first competition, whichever comes first.***

Documents are available in the 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 the first practice to the main office.

Please do not hand in forms individually.

Coaches are NOT allowed to collect paperwork.

Online forms—are completed during school registration in August on PowerSchool

■ 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 eligibility 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 _____

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 _____

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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.
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SIGNATURE OF PARENT _____ DATE _____

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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

2021-22 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:

		<u>Annual Premium</u>
A. Full-Time (24 hour) - with No Sports	Grades K-12	\$ 99.00
Full-Time (\$89.00) - with All Sports (except football, Grades 9-12)	Grades 7-12	\$ 174.00
B. School-Time - with No Sports	Grades K-12	\$ 16.00
School-Time - with All Sports (except football, Grades 9-12)	Grades 7-12	\$ 99.00
C. Extended Dental Coverage	Grades K-12	\$ 9.00
D. Football ONLY Coverage (football, Grades 7&8 are covered by the All Sports Coverage)	Grades 9-12	\$ 250.00

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 _____

PORT WASHINGTON HIGH SCHOOL
2021-22 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 _____

2021-22 Life of a Pirate Activities Code Examination

The examination below is a required eligibility requirement of all students participating in Port Washington High School extra-curricular activities. The examination below contains 40 questions requiring a True or False response taken directly from the Student Activities Handbook (Life of a Pirate Activities Code). The student/parent or guardian must obtain a score of 35 or greater. Individuals receiving a score of less than 35 must retake the exam to obtain athletic eligibility.

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- 1) Participation in High School Activities is a Student "Right."
- 2) Students must carry a class load of at least 3 credits per semester of course work at all times to maintain eligibility.
- 3) Academic eligibility: Students may obtain 1 Failing grade and remain eligible.
- 4) A student receiving a Second Semester Failing Grade may complete and pass a summer school course to regain eligibility in a Fall Activity.
- 5) Academic ineligibility status may be adjusted for fall and summer activities based upon season start dates.
- 6) General Conduct in the classroom has no bearing on activity consequences.
- 7) Attendance is required for the entire school day, unless pre-approved, to be eligible for practice or competition. A parent must provide verification for and from the service provider for the absence to be approved.
- 8) Following a competition on a school night that goes late into the evening, it is OK to be late or not attend first hour classes the following day.
- 9) Unexcused absences from practices, meetings, or competitions will be handled by the parents of the student in question.
- 10) Athletes may freely change sports within the same sport season if they are unhappy in their present experience.
- 11) An Athlete may NOT participate in 2 sports within the same season unless formal approval is granted by the Athletic Director.
- 12) School provided transportation to and from activities must be used by students involved in such activities.
- 13) Spectators, participants, and/or parents may be removed from events if poor sportsmanship persists.
- 14) A parent is allowed to contact the Athletic Director immediately if they are concerned about their child's playing time.
- 15) The enforcement period for the Activities code begins with the first day of school for all incoming freshman.
- 16) Demerit points are issued to students involved in activities for failing grades. (see "Penalties for Violations of the Act. Code")
- 17) 3 Demerit points are assessed to students that are in the "presence" of illegal drug and alcohol use.
- 18) A 7 Demerit point offense and a minimum of a 50% of a season suspension is the result of hosting a party where drugs and alcohol are consumed. Likewise, individuals that supply or distribute drugs and alcohol will receive the same penalty.
- 19) Acts of hazing are not included into the violations of the Activities Handbook
- 20) Students are provided with a 1-time only honesty clause worth 2 Demerit points for drug and alcohol use offenses.

- 21) Students under suspension for drug and/or alcohol use must complete a drug and alcohol assessment.
- 22) Once a student has collected his or her 5th demerit point, a 33% of a season suspension is applied.
- 23) Once a 9th demerit point is incurred, a 50% of a season suspension is applied.
- 24) Students may be held out of activities for 1 year if they knowingly participate when ineligible academically or otherwise
- 25) Students that collect 11 or more demerit points are ineligible to participate in activities for the remainder of their HS career.
- 26) A student's demerit point record is cleared upon serving a suspension.
- 27) Students can earn back a maximum of 3 points per school year through community service.
- 28) 10 hours of community service equals 2 points
- 29) A \$20 late fee will be assessed for fees that are unpaid prior to the first date of competition.
- 30) An Athletic Trainer Consent form is 1 of 8 elements required to participate in a High School Activity.

WIAA BULLETIN QUESTIONS:

- 31) A student shall be ineligible if he or she reaches 19 years of age before August 1 of any given school year.
- 32) A student is deemed ineligible if he or she have graduated through grade 12 or its equivalent.
- 33) 9th grade students who transfer "before" the beginning of the school year shall be restricted to non-varsity opportunities.
- 34) 10th or 11th grade students that transfers "after" the beginning of the school year shall be restricted to non-varsity opportunities.
- 35) A physical examination is required every 2 years.
- 36) A student-athlete, disqualified from a contest by an official for conduct, is suspended from the next competition.
- 37) It is acceptable for athletes to appear in the promotion of a commercial/advertisement or profit-making event.
- 38) It is unacceptable to participate in an out-of-season activity that is the same as one's in-season activity.
- 39) A Student Athlete or his/her parents must pay own fees for specialized training or instruction such as camps and clinics.
- 40) In order to facilitate good communication with the WIAA, all questions regarding athletic participation at our school should be addressed to the Athletic Director.

STUDENT ATHLETE _____(Print) PARENT _____(Print)

STUDENT ATHLETE _____(Signature) PARENT _____(Signature)

WIAA ELIGIBILITY BULLETIN

**PARENT-ATHLETE WIAA RULES OF ELIGIBILITY
SIGN-OFF FORM**

2021-22

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
Sports Medicine Emergency Information and Consent**

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

IN CASE OF EMERGENCY, PLEASE NOTIFY:

First, Try: Parent/Guardian Alternate Emergency Contact
Then, Try: Parent/Guardian 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** 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, if a minor, 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** 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; the athletic trainer may evaluate and treat other emergent or non-emergent Student injuries or medical conditions, including concussion baseline testing, brought to the athletic trainer's attention as they relate to the Student's physical activity, conditioning or injury prevention, regardless of whether or not the Student participates in athletics.
- 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.

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(if student is a minor) Parent Guardian (relationship) _____

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: _____

2021-22 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 2018-19 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.