Benzie Central High School

Athletic Packet

Benzie Central Athletics

Dear Parent(s) and Athlete,

Welcome to the 2018/19 Benzie Central Sports season! We are delighted that you are joining us and we want to help you be successful in completing the necessary documents for participation. This packet will give you the necessary forms needed by your coach, athletic trainer, school administration and MHSAA. Please make sure that all forms and payment are completed prior to submitting to your coach. It is very important that all information is provided. Please notice that many forms, including the Athletic Release form requires both a parent and athlete signature.

Thank you,

Benzie Central Athletic Department

- Student Athletic Emergency Information (for Coach)
- Athletic Release Form (for School)
- Concussion Information Sheet
- Consent for Medical Treatment Form (for Athletic Trainer)
- Sports Physical (must be dated by physician on or after April 15, 2018, to be valid for the 2018/19 school year)
- Pay to Participate fees (to HS Office)

Pay to Participate Fees

HS Participation Fees	MS Participation Fees
$35 per sport	$25 per sport
Or	Or
$100 max per school year	$70 max per school year

Families-MS or HS-$200 max for the school year

Athletic Sports Passes

Pay one price and get in all season!

$100-Family

$55-Adult

$25-Student

For all questions and payment for both Pay to Participate and Athletic Sports Passes, please see Mrs. Meachum in the MS/HS office. All checks can be made to Benzie Central High School (BCHS).

Benzie Central Athletic Department

Student Athlete Emergency Information Form

Parents and/or Guardians:

The following is a permission form that must be completed and signed by you and your student athlete before they may participate in an interscholastic athletic event for Benzie Central Schools. In signing this letter you should be aware of the following important points:

1. Benzie Central Schools **DOES NOT** provide an insurance program covering health or injury problems resulting from athletics. It is the responsibility of the athlete and their family to provide such insurance and to take care of any medical expenses.
2. In signing this form you are giving your student athlete permission to travel under the coach's direction and authority to and from athletic events.
3. The coaches shall have the authority to seek medical attention in case of injury in any athletic gathering (practice, contests or authorized team activity).

Athlete Name:_____

Birthdate:_____Grade:_____Gender: Male Female

Address:_____

City:_____ Zip:_____

Parent/Guardian Name:_____

Phone (home/cell):_____Work (mom/dad):_____

IF AN EMERGENCY SHOULD OCCUR AND PARENTS CANNOT BE REACHED, THE FOLLOWING INDIVIDUALS WILL BE CALLED:

Emergency #1:_____ Phone:_____

Emergency #2:_____ Phone:_____

Physician:_____ Phone:_____

Hospital Choice:_____

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated and to follow their instructions. If the physician cannot be reached, the school may make whatever arrangements deemed necessary for the well-being of the child. I understand medical information may be provided to the Athletic Department for my child to participate in interscholastic athletics. This information will be treated with full confidentiality by this department.

Athlete Signature:_____Date:_____

Parent Signature:_____Date:_____

MEDICAL HISTORY

Indicate any issues we need to be aware of for the health and well-being of your student.

ALLERGIES:_____ASTHMA:_____

SEIZURES:_____ DIABETES:_____

CARDIAC:_____SURGERIES:_____

CURRENT MEDICATIONS:_____

Athletic Release Form

Athlete's Name:_____

Grade:_____ Sport(s) Participating in this school year:_____

Parents/Guardians Name:_____

Home Phone:_____Cell Phone:_____Work Phone:_____

Home Address:_____

Mailing Address:_____

City:_____Zip:_____

Email (parents):_____

Email (students):_____

By signing this form, you are indicating that you have read, understand and will support the rules, policies and procedures of the Benzie County Central Schools.

You are also acknowledging the fact that you understand athletics have an inherent risk involved while participating in sports. The coaches and staff are trained to maintain your athlete's safety as their most important priority, but you must also remind your athlete they need to follow the directions given by the coaching staff.

Understand at times, the media and other educational institutions request information about your athlete and their athletic activities, you understand we will provide only the following items: name, grade, individual and/or team pictures, game statistics, and annual awards, other information will only be supplied with proper releases from the counseling office and principal's office.

I hereby give my consent for my athlete (name) _____ to engage in interscholastic athletics and for the disclosure of the MHSAA of information otherwise protected by FERPA and HIPPA for the purpose of determining eligibility for interscholastic athletics: and I understand the possibility that serious injury may result from participating in athletic activities. My athlete has my permission to accompany the team as a member on its out-of-town trips. I further understand that my son/daughter will be expected to adhere firmly to all established athletic policies of Benzie County Central Schools and the Michigan High School Athletic Association.

_____ _____

Student/athlete Signature Parent/guardian Signature

_____ _____

Date Date

PARENT & ATHLETE CONCUSSION INFORMATION SHEET

WHAT IS A CONCUSSION?

A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by a bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

WHAT ARE THE SIGNS AND SYMPTOMS OF CONCUSSION?

Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks 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 kept out of play the day of the injury. The athlete should only return to play with permission from a health care professional experienced in evaluating for concussion.

DID YOU KNOW?

- Most concussions occur without loss of consciousness.
- Athletes who have, at any point in their lives, had a concussion have an increased risk for another concussion.
- Young children and teens are more likely to get a concussion and take longer to recover than adults.

SYMPTOMS REPORTED BY 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"

SIGNS OBSERVED BY COACHING STAFF:

- 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

[INSERT YOUR LOGO]

"IT'S BETTER TO MISS ONE GAME THAN THE WHOLE SEASON"

CONCUSSION DANGER SIGNS

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. An athlete should receive immediate medical attention if after a bump, blow, or jolt to the head or body s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that gets worse
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people or places
- Becomes increasingly confused, restless, or agitated
- Has unusual behavior
- Loses consciousness (even a brief loss of consciousness should be taken seriously)

WHAT SHOULD YOU DO IF YOU THINK YOUR ATHLETE HAS A CONCUSSION?

1. If you suspect that an athlete has a concussion, remove the athlete from play and seek medical attention. Do not try to judge the severity of the injury yourself. Keep the athlete out of play the day of the injury and until a health care professional, experienced in evaluating for concussion, says s/he is symptom-free and it's OK to return to play.

2. Rest is key to helping an athlete recover from a concussion. Exercising or activities that involve a lot of concentration, such as studying, working on the computer, and playing video games, may cause concussion symptoms to reappear or get worse. After a concussion, returning to sports and school is a gradual process that should be carefully managed and monitored by a health care professional.

3. Remember: Concussions affect people differently. While most athletes with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer.

WHY SHOULD AN ATHLETE REPORT THEIR SYMPTOMS?

If an athlete has a concussion, his/her brain needs time to heal. While an athlete's brain is still healing, s/he is much more likely to have another concussion. Repeat concussions can increase the time it takes to recover. In rare cases, repeat concussions in young athletes can result in brain swelling or permanent damage to their brain. They can even be fatal.

STUDENT-ATHLETE NAME PRINTED

STUDENT-ATHLETE NAME SIGNED

DATE

PARENT OR GUARDIAN NAME PRINTED

PARENT OR GUARDIAN NAME SIGNED

DATE

HEADS UP

JOIN THE CONVERSATION www.facebook.com/CDCHeadsUp

TO LEARN MORE GO TO >> WWW.CDC.GOV/CONCUSSION

Content Source: CDC's Heads Up Program. Created through a grant to the CDC Foundation from the National Operating Committee on Standards for Athletic Equipment (NOCSAE).

MUNSON HEALTHCARE
Paul Oliver Memorial Hospital

Concussion Information Sheet for Athletes, Parents or Legal Guardians

What is a concussion? A concussion is an injury to the brain caused by a direct or indirect blow to the head. It results in your brain not working as it should. The concussion may or may not cause you to black out or pass out. It can happen from a fall, a hit to the head, or a hit to the body that causes your head and your brain to move quickly back and forth.

How do I know if I have a concussion? There are many signs and symptoms that you may have after a concussion. A concussion can affect your thinking, the way your body feels, your mood, or your sleep. Here is what to look for the following symptoms:

Thinking	Physical	Emotional/Mood	Sleep
• Difficulty thinking clearly • Taking longer to figure things out • Difficulty concentrating • Difficulty remembering new information	• Headache • Fuzzy or blurry vision • Feeling sick to your stomach/queasy • Vomiting/throwing up • Dizziness • Balance problems • Sensitivity to noise or light	• Irritability-things bother you more easily • Sadness • Being more moody • Feeling nervous or worried • Crying more	• Sleeping more than usual • Sleeping less than usual • Trouble falling asleep • Feeling tired

Table is adapted from the Centers for Disease Control and Prevention (http://cdc.gov/concussions/).

What should I do if I think I have a concussion? If you are having any of the signs and symptoms listed above, you should tell your parents, coach, athletic trainer, or school nurse, so you can get the help you need. If a parent notices these symptoms, he or she should inform the school nurse or athletic trainer.

When should I be particularly concerned? If you have a headache that gets worse over time, you are unable to control your body, you throw up repeatedly or feel more and more sick to your stomach, or your words are coming out funny or slurred, let an adult such as your parent, coach, or teacher know right away, so you can get the help you need before things get any worse.

What are some of the problems that may affect me after a concussion? You may have trouble in some of your classes at school or even with activities at home. If you continue to play or return to play too early after a concussion, you may have long-term trouble remembering things or paying attention, headaches may last a long time, or personality changes can occur. Once you have a concussion, you are more likely to have another concussion.

How do I know when it's ok to return to physical activity and my sport after a concussion? After telling your coach, your parents, and any available medical personnel that you think you have a concussion. According to the Benzie Central and POMH Concussion policy, you must follow the concussion management flow sheet and appropriate return to sport protocol administered by a trained appropriate medical profession (Athletic Trainer or Physical Therapist). Then be referred to a physician to be cleared by them. **You CAN NOT return to play or practice on the same day as your suspected concussion occurred due to MHSAA rules. You must have the official MHSAA unconditional return to sport form in order to return.**

You should not begin the return-to-play progression, until all symptoms are gone, both at rest and during and after activity, unless allowed to by Certified Athletic Trainer or other trainer

professional. Symptoms indicate that your brain has not yet recovered from the concussion and needs more rest.

**If there is anything on this sheet that you do not understand, please ask an adult to explain or read it to you.*

Athlete Name:

_____

This form must be completed by every athlete, even if there are multiple athletes in the household.

Parent or Legal Guardian Name(s):

_____

Review and sign even if athlete is 18 or older

☐ We have read the "Athlete and Parent or Legal Guardian Concussion Information Sheet
If true, please check box

Athlete Initials	After reading the information sheet, I am aware of the following information:	**Parent or legal guardian Initials**
_____	A concussion is a brain injury, which should be reported to my parents, my coach(es), or athletic trainer.	
	A concussion can affect the ability to perform everyday activities such as ability to think, balance, and perform in the classroom.	
	A concussion cannot be "seen." Some symptoms might be present right away. Other symptoms can show up hours or days after an injury.	
_____	I will tell my parents, my coach, or athletic trainer about my injuries and illnesses.	Not Applicable
_____	If I think a teammate has a concussion, I should tell my coach(es), parents or athletic trainer.	Not Applicable
_____	I will not return to play in a game or practice if a hit to my head or body causes any concussio related symptoms.	Not Applicable
_____	I will/my child will need written permission from a medical professional trained in concussion management to return to play or practice after a concussion, an athletic trainer then a doctor.	_____
	According to the latest data, most concussions take days or weeks to get better. A concussion may not go away right away. I realize that resolution from this injury is a process and may require more than 1 medical evaluation.	
_____	I realize that emergency department or urgent care physicians will not provide clearance if the patient is seen right away after the injury.	_____
_____	After a concussion, the brain needs time to heal. I understand that I am/my child is much more likely to have another concussion or more serious brain injury, even death, if return to play or practice occurs before concussion symptoms go away.	_____
	Sometimes, repeat concussions can cause serious and long-lasting problems.	

I have read and understand the concussion symptoms on the Concussion Information Sheet.

_____ _____

Signature of athlete Date

_____ _____

Signature of Parent or Legal Guardian Date

Consent for Medical Treatment

Benzie Central High School-Athletic Training

I,_____, an 18-year old or Parent or legal guardian of _____, born_____, recognize that as a result of athletic participation, medical treatment on an emergency basis may be necessary, and further recognize that school personnel may be unable to contact me for my consent for emergency medical care. The emergency medical care initially, will be provided by a Certified Athletic Trainer or Board Certified Sports Clinical Specialist in Physical Therapy (SCS). I do herby consent in advance to such emergency care, including hospital care, as deemed necessary under the then-existing circumstances and to assume the expenses of such care.

Student's Name:_____Gender:_____Grade:_____

Emergency Contact 1 Name:_____

Cell:_____ Work:_____ Relation:_____

Emergency Contact 2 Name:_____

Cell:_____ Work:_____ Relation:_____

_____ Date:_____

Signature of Parent or Guardian or 18 year-old

BENZIE COUNTY CENTRAL SCHOOLS
VOLUNTEER RELEASE FORM

I have offered my services as a volunteer to help the School District in the following area(s):

I agree to abide by all relevant Board policies and administrative guidelines while on duty for the District. I understand that, although I am covered under the District's liability insurance policy, I am not covered by its health insurance policy nor am I eligible for workers' compensation. Should I become ill or suffer an accident while doing volunteer work for the District, I agree that I shall be responsible for any and all hospital and medical charges that may accrue.

I understand further that, as a volunteer, I am not in any manner considered an employee of the District or entitled to any benefits provided to employees. I further release the Board of Education from any and all liability for any damages, whatever their nature, which may result as a consequence of my volunteer services.

For the protection of the children in the school, the District is required by law to inquire of its staff members whether or not they have ever been convicted of a crime related to children. We would appreciate your cooperation by indicating that you have never been convicted of any of the following offenses: aggravated murder, murder, voluntary manslaughter, involuntary manslaughter, felonious assault, aggravated assault, assault, aggravated menacing, abuse or neglect of a child, kidnapping, abduction, child stealing, criminal child enticement, rape, sexual battery, corruption of a minor, gross sexual imposition, importuning, voyeurism, public indecency, felonious sexual penetration, compelling prostitution, promotion prostitution, procuring prostitution, disseminating matter harmful to juveniles, pandering obscenity, pandering obscenity involving a minor, pandering sexually-oriented matter involving a minor, illegal use of a minor in nudity-oriented material or performance, endangering children, contribution to the delinquency of children, carrying concealed weapons, improperly discharging a firearm at or into a school or house, corrupting another with drugs, placing harmful objects in or adulterating food or confection.

By completing the information below and signing this form, I authorize Benzie County Central Schools to seek and acquire the necessary information through a criminal history records check.

Print Name: _____

Address: _____

Phone: _____ Date of Birth: _____ Race: _____ Sex: _____

Maiden Name/Alias: _____

_____	_____	_____
Volunteer Signature	District Witness	Date

BENZIE COUNTY CENTRAL SCHOOLS
APPLICATION FOR PARENT-DESIGNATED VOLUNTEER DRIVER

I wish to assist the education of children in the Benzie County Central Schools and therefore apply to become a volunteer driver to transport student(s) in a non-school owned vehicle to/from a school-related event and as authorized by that student's parent/legal guardian. In return for authorizing my status as a parent-designated volunteer driver, I make the following representations and commitments:

Driver's Name _____ Date of Birth _____
Address _____ Phone No. _____
Maiden Name or Alias _____

Operator's License No. _____ License Expiration Date _____
License Restrictions _____

Vehicle/Make/Model/Year _____ Vehicle Owner _____
Vehicle Insurance Company _____ Policy No. _____
Policy Coverage Period _____ Liability Limit _____

1. I *have/have not* (circle one) been convicted of an alcohol/drug-related driving violation in the past 10 years.

2. I currently have __ points on my driving record for _____ (list citations and dates).

3. I agree to abide by the requirements of all applicable laws at all times during which I am engaged as a parent-designated volunteer driver, including but not limited to requiring each passenger to use a seat belt.

4. I will promptly report to the school administrator any of the following which may occur after the application date.

   A. Motor vehicle accident (regardless of whether the accident occurs while I am volunteer driving),
   B. Suspension/revocation of my operator's license,
   C. Change in the status of my motor vehicle insurance status, and
   D. Change in my ability to safely drive a motor vehicle

5. I will maintain at all times liability insurance which covers passengers in my vehicle while I am a volunteer driving a student to/from a school-related event.

6. I will not use a vehicle with a manufacturer's-rated seating capacity of 11 or more passengers, including the driver, to transport a student to/from a school-related event.

7. I will maintain the vehicle so it can be safely operated.

8. I understand that:

   A Damage to the owner's vehicle is not insured by the Benzie County Central Schools.
   B. In case of any insurance claim, the owner's vehicle insurance provides primary coverage and the general liability insurance of the Benzie County Central Schools provides excess coverage, if any, pursuant to the limitations of the insurance contract.

I have read and understand the above requirements to be a parent-designated volunteer driver and I agree to abide by these requirements.

_____ _____
Driver's Signature Date

_____ _____
Administrator's Signature Date

Authority: Board Policy ____; MCL 257.6(3)(h), MCL 257.1807(1)
Approval Date: __/__/09

Attachments (photocopies)

☐ Operator's license ☐ Vehicle insurance card ☐ Vehicle registration

michigan high school athletic association

MEDICAL HISTORY: Completed by Parent or Guardian or 18-Year-Old

Student Name: _____ Date of Birth: _____

Doctor: _____ Doctor's Phone: _____ Date of Exam: _____

- GENERAL QUESTIONS	Y	N
Has a doctor ever denied or restricted your participation in sports for any reason?		
Do you have any ongoing medical conditions? If so, please identify below:		
❑ Asthma ❑ Anemia ❑ Diabetes ❑ Infections ❑ Other:		
Have you ever spent the night in the hospital or have you ever had surgery?		
- HEART HEALTH QUESTIONS ABOUT YOU	**Y**	**N**
Have you ever passed out or nearly passed out DURING or AFTER exercise?		
Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
Does your heart ever race or skip beats (irregular beats) during exercise?		
Has a doctor ever told you that you have any heart problems? Check all that apply:		
❑ High blood pressure ❑ Heart murmur ❑ Heart infection ❑ High cholesterol		
❑ Kawasaki disease ❑ Other:		
Has a doctor ordered a test for your heart? (example, ECG/EKG, echocardiogram)		
Do you get lightheaded or feel more short of breath than expected during exercise?		
Do you have a history of seizure disorder or had an unexplained seizure?		
Do you get more tired or short of breath more quickly than your friends during exercise?		
- HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Y**	**N**
Has anyone in your family had unexplained fainting, unexplained seizures or near drowning?		
Does anyone in your family have a heart problem, pacemaker or implanted defibrillator?		
Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)?		
Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome or catecholaminergic polymorphic ventricular tachycardia?		
- BONE AND JOINT QUESTIONS	**Y**	**N**
Have you ever had an injury to a bone, muscle, ligament or tendon that caused you to miss a practice or a game?		
Have you ever had any broken or fractured bones, dislocated joints or stress fracture?		
Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast or crutches?		
Do you regularly use a brace, orthotics or other assistive device?		
Do you have a bone, muscle or joint injury that bothers you?		
Do any of your joints become painful, swollen, feel warm or look red?		
Do you have any history of juvenile arthritis or connective tissue disease?		
Have you ever had an x-ray for neck instability or atlantoaxial instability (Down syndrome or dwarfism)?		

- MEDICAL QUESTIONS	Y	N
Do you cough, wheeze or have difficulty breathing during or after exercise?		
Have you ever used an inhaler or taken asthma medicine?		
Is there anyone in your family who has asthma?		
Were you born without, or missing a kidney, eye, testicle (males), spleen or any other organ?		
Do you have groin pain or a painful bulge or hernia in the groin area?		
Have you had infectious mononucleosis (mono) within the last month?		
Do you have any rashes, pressure sores or other skin problems?		
Have you had a herpes or MRSA skin infection?		
Do you have headaches or get frequent muscle cramps when exercising?		
Have you ever become ill while exercising in the heat?		
Do you or someone in your family have sickle cell trait or disease?		
Have you had any problems with your eyes or vision or any eye injuries?		
Do you wear glasses or contact lenses?		
Do you wear protective eyewear such as goggles or a face shield?		
Immunization History: Are you missing any recommended vaccines?		
Do you have any allergies?		
Have you ever had a head injury or concussion?		
Do you have any concerns that you would like to discuss with a doctor?		
Have you ever received a blow to the head that caused confusion, prolonged headache or memory problems?		
Have you ever had numbness, tingling, weakness or inability to move your arms or legs after being hit or falling?		
Have you ever had an eating disorder?		
Do you worry about your weight?		
Are you trying to or has anyone recommended that you gain or lose weight?		
Are you on a special diet or do you avoid certain types of foods?		
- FEMALES ONLY (Optional)	**Y**	**N**
Have you ever had a menstrual period?		
How old were you when you had your first menstrual period?		
How many periods have you had in the last 12 months?		

CURRENT-YEAR PHYSICAL = GIVEN ON OR AFTER APRIL 15 OF THE PREVIOUS SCHOOL YEAR

PHYSICAL EXAMINATION & MEDICAL CLEARANCE: Completed by MD, DO, PA or NP - RETURN DIRECTLY TO PATIENT

EXAMINATION: Height: Weight: ❑ Male ❑ Female BP: / Pulse: Vision: R 20/ L 20/ Corrected: ❑ Y ❑ N

MEDICAL	NORMAL	ABNORMAL	MUSCULOSKELETAL	NORMAL	ABNORMAL
Appearance: Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)			Neck		
Eyes/Ears/Nose/Throat: Pupils Equal Hearing			Back		
Lymph nodes			Shoulder/Arm		
Heart: Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (PMI)			Elbow/Forearm		
Pulses: Simultaneous femoral and radial pulses			Wrist/Hand/Fingers		
Lungs			Hip/Thigh		
Abdomen			Knee		
Genitourinary (males only)			Leg/Ankle		
Skin: HSV: Lesions suggestive of MRSA, tinea corporis			Foot/Toes		
Neurologic			Functional Duck Walk		

RECOMMENDATIONS: _____

I certify that I have examined the above student and recommend him/her as being able to compete in supervised athletic activities NOT crossed out below.

BASEBALL – BASKETBALL – BOWLING – COMPETITIVE CHEER – CROSS COUNTRY – FOOTBALL – GOLF – GYMNASTICS – ICE HOCKEY
LACROSSE – SKIING – SOCCER – SOFTBALL – SWIMMING/DIVING – TENNIS – TRACK & FIELD – VOLLEYBALL – WRESTLING

EXAMINER

Name of Examiner (print/type): _____ Date: _____

Signature of Examiner: _____ (Check One): ❑ MD ❑ DO ❑ PA ❑ NP

- (DETACH HERE IF NEEDED TO ACCOMPANY STUDENT-ATHLETE) -

EMERGENCY INFORMATION: COMPLETED BY PARENT or GUARDIAN or 18-YEAR-OLD

Student: _____ Grade: _____ Doctor: _____ Phone: (_____)_____

IN EMERGENCY (1): _____ Home #: (_____)_____ Cell #: (_____)_____

IN EMERGENCY (2): _____ Home #: (_____)_____ Cell #: (_____)_____

Drug Reactions: _____ Current Medications: _____

Allergies: _____

michigan high school athletic association

PRE-PARTICIPATION PHYSICAL - CONSENT - INSURANCE

Shaded headline areas are to be completed by student, parent/guardian or 18-year-old

There are **FOUR** (4) signatures on this page ➡ 4 ⬅ to be completed by student, parent/guardian and/or 18-year-old

A CURRENT-YEAR PHYSICAL IS ONE GIVEN ON OR AFTER APRIL 15 OF THE PREVIOUS SCHOOL YEAR

Student Name: _____
LAST FIRST MIDDLE INITIAL

Student Address: _____
STREET CITY ZIP

Gender: ❑ M ❑ F Age: _____ Date of Birth: _____ Place of Birth (City/State): _____

School: _____ Circle Grade: **6 7 8 9 10 11 12**

Father/Guardian Name: _____

Phone (home): _____ (work): _____ (cell): _____

Mother/Guardian Name: _____

Phone (home): _____ (work): _____ (cell): _____

Email Address: Parent/Guardian/18-Year-Old: _____

STUDENT PARTICIPATION & PARENT or GUARDIAN or 18-YEAR-OLD CONSENT

The information submitted herein is truthful to the best of my knowledge. By my/my child's signature below, **I/we acknowledge that I/we have received concussion educational information that meets Michigan Department of Health and Human Services and MHSAA requirements**.

Further, in consideration of my/my child's participation in MHSAA-sponsored athletics, I/we do hereby agree, understand, appreciate, and acknowledge: **that participation in such athletics is purely voluntary; that such activities involve physical exertion and contact and that there is inherent risk of personal injury associated with participation in such activities, which risk I/we assume;** and that I/we agree to, and hereby waive any and all claims, suits, losses, actions, or causes of action against the MHSAA, its members, officers, representatives, committee members, employees, agents, attorneys, insurers, volunteers, and affiliates based on any injury to me, my child, or any person, whether because of inherent risk, accident, negligence, or otherwise, during or arising in any way from my/my child's participation in an MHSAA-sponsored sport.

I/we understand that I am/we are expected to adhere firmly to all established athletic policies of my school district and the MHSAA. I/we hereby give my consent for the above student to engage in interscholastic athletics and for the disclosure to the MHSAA of information otherwise protected by FERPA and HIPAA for the purpose of determining eligibility for interscholastic athletics. My child has my permission to accompany the team as a member on its out-of-town trips.

➡ 1 ⬅ Signature of **STUDENT**: _____ Date: _____

➡ 2 ⬅ Signature of **PARENT** or **GUARDIAN** or **18-YEAR-OLD**: _____ Date: _____

INSURANCE STATEMENT

Our son/daughter will comply with the specific insurance regulations of the school district.

The student-athlete has health insurance: ❑ YES ❑ NO

If YES, Family Insurance Co: _____ Insurance ID #: _____

Additionally, I hereby state that, to the best of my knowledge, my answers to the medical history questions (see reverse) are complete and correct.

➡ 3 ⬅ Signature of **PARENT** or **GUARDIAN** or **18-YEAR-OLD**: _____ Date: _____

- (DETACH HERE IF NEEDED TO ACCOMPANY STUDENT-ATHLETE) -

MEDICAL TREATMENT CONSENT: COMPLETED BY PARENT or GUARDIAN or 18-YEAR-OLD

I, _____, an 18-year-old, or the parent or guardian of _____, recognize that as a result of athletic participation, medical treatment on an emergency basis may be necessary, and further recognize that school personnel may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the then-existing circumstances and to assume the expenses of such care.

➡ 4 ⬅ Signature of **PARENT** or **GUARDIAN** or **18-YEAR-OLD**: _____ Date: _____