Preparticipation Physical Evaluation
CLEARANCE FORM

Grade: _____

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).

Dr. Please sign & date here

Name of Physician (Print/Type) _____

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

Clinic Name _____

Address/Clinic _____ City _____ State _____ Zip Code _____

Telephone _____ Date of Examination _____

* Physicians may authorize Nurse Practitioners or Physician Assistants 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 _____

KENOSHA UNIFIED SCHOOL DISTRICT
PARENT-ATHLETE ACTIVITIES CODE AND
WIAA RULES OF ELIGIBILITY
SIGN-OFF FORM

This form must be completed and submitted to the Athletic Director prior to a student being declared eligible for practice and competition.

WE, THE PARENTS OF_____, HAVE READ, UNDERSTAND, AND HAVE DISCUSSED
Please Print
THE ACTIVITIES CODE OF CONDUCT AND THE WIAA RULES OF ELIBIBILITY WITH OUR SON/DAUGHTER. WE FURTHER AGREE TO PERMIT OUR SON/DAUGHTER TO PARTICIPATE IN ACCORDANCE WITH THE CONDITIONS SET FORTH IN THE ACTIVITIES CODE OF CONDUCT. WE FUTHER CERTIFY THAT IF WE DID NOT UNDERSTAND ANY OF THE INFORMATION IN BOTH DOCUMENTS, WE HAVE SOUGHT AND RECEIVED AN EXPLANATION OF THE INFORMATION PRIOR TO SIGNING THIS STATEMENT.

_____ _____
Student's Signature (Required) **Grade**

_____
Parent's Signature (Only one parent's signature required)

_____
Date

COACHES/ADVISORS MUST RETAIN A SIGNED COPY OF THIS FORM IN THEIR FILES FOR EACH STUDENT INVOLVED IN THEIR ACTIVITY

One agreement must be signed each year for all student participation in Categories 1, 2, and 3 activities.
Please list the activities your son/daughter will be involved in during the present school year.

SPORTS	ACTIVITIES

KENOSHA UNIFIED SCHOOL DISTRICT NO. 1
ATHLETIC PERMISSION FORM

Student Name: _____Grade Level_____

Address: _____ Zip Code: _____ Birth Date: _____

Telephone ( ) _____ Cell Phone ( ) _____

School_____

Health Insurance Carrier: _____Policy Number: _____

Permission to Participate

I hereby give my permission for the above-named student to practice, compete, and represent the school in WIAA regulated interscholastic sports except any restrictions as noted on the current, effective physical examination card as completed by a licensed physician or advanced practice nurse prescriber. This letter shall be provided to each student when they sign up to participate in a sport. No athlete will be permitted to participate until this form is signed and on file with building athletic director. Plus, this form serves as a notification of parental (guardian) permission to participate in the sport of: _____.
(Sport)

Responsibility to Return All School-Issued Uniforms/Equipment

I agree to be financially responsible for the safe return of all athletic uniforms and equipment issued to him/her. I understand that my son/daughter is responsible for any uniform or equipment that is assigned specifically to him/her, and agree to reimburse the school the actual replacement value of the uniforms/equipment in the event that they are lost or stolen. I understand that failure to reimburse KUSD#1 in a timely fashion could affect my son/daughter's athletic eligibility.

Permission for Emergency Medical Care and Conveyance

I further grant permission for my son/daughter, named above, in case of injury as a result of athletic participation, to be given emergency attention/care by the coaching staff, athletic trainer, the team physician or any other physician present, and to be conveyed to an emergency medical facility, if needed. I understand that all medical costs that could occur from such conveyance and subsequent treatment are the sole responsibility of the parents/guardians, and I understand that KUSD #1 will assume no liability for the cost of said conveyance or treatment.

Informed Consent

I understand that injuries could occur as a result of participation in athletics. I understand that these injuries could include minor injuries such as bruises or abrasions, muscle strains, sprains, or broken limbs. I understand that it is possible that a catastrophic injury could occur rendering my son/daughter paralyzed, and that death could also occur as a result of a catastrophic injury.

Insurance Waiver

I certify that I have adequate insurance coverage on the above-named student to cover medical expenses in the event of an athletic-related accident or injury.

Signature

By signing this form I am attesting to the fact that I understand and agree to all conditions set forth on this form and that if I have not understood any information, I have sought and received an explanation, and I am fully aware that I am granting permission for the above-named student to participate in the KUSD #1 Athletic Program.

_____ _____ _____ _____
Parent/Guardian Signature Date Student-Athlete Signature Date

Kenosha Unified School District

In accordance with Wisconsin's Sidelined For safety Act 172, we the undersigned acknowledge having received education about the signs, symptoms, and risks of sport related concussion. We understand that students are prohibited from any participation until this form is completed and returned to the school's Athletic Office.

I acknowledge my responsibility to report to my coaches, parent(s)/guardian(s) any signs or symptoms of a concussion and agree to abide by all KUSD concussion protocols.

_____

printed name of student/athlete *signature* *date*

I, the parent/guardian of the student athlete named above, hereby acknowledge having received education about the signs, symptoms, and risks of sport related concussion and agree to abide by all KUSD concussion protocols.

_____

printed name of parent/guardian *signature* *date*

Kenosha Unified School District

What is a Concussion and How Does It Occur?

A concussion is a brain injury which interferes with normal brain function. This affects the way an individual thinks, acts, behaves, and the physical skills needed to function on a daily basis. Each concussion is unique to each person, but there are some common signs and symptoms to be aware of to determine if an individual has a concussion.

A concussion can be caused by a bump, blot, jolt or fall to the head or body. When the head or body is bumped, hit, etc. the force of that movement causes the brain to hit the sides of the skull or move and/or twist while inside the skull. These movements change the way the physiology of the brain normally works. Even a mild blow to the head of body can cause the brain to shift or move in the skull, thus injuring the brain.

What are the Signs and Symptoms of a Concussion?

Once a concussion is sustained, more signs and symptoms can develop in the next 24 hours, even in the next week. The severity and side effects of this brain injury will vary depending on the individual. Concussion symptoms may appear mild, but can lead to lifelong problems mentally, physically and psychologically if not managed correctly. A person can have signs and symptoms of a concussion without the loss of consciousness. Symptoms of a concussion can last for less than 1 day or up to 3 weeks or more.

Most of the time, images taken with a CT, MRI or CAT scan appear normal and do not show the physiologic changes that occur to the brain with a concussion. Image studies are done to rule out other head injuries, such as skull fractures.

Signs and Symptoms of a Concussion

Thinking/Remembering	Physical	Emotional/Mood	Sleep
Difficulty Thinking Clearly	Head ache	Irritability	Sleeping more than usual
Feeling Slowed Down or Foggy	Fuzzy or Blurred Vision	Sadness or More Emotional	Sleeping Less than usual
Difficulty Concentrating or Focusing	Nausea or Vomiting	Nervousness	Trouble Falling Sleep
Amnesia	Dizziness	Anxiety	Can't Stay Asleep
Difficulty Remembering New or Old Information	Sensitivity to Light or Noise	Slow to Respond or Easily Confused	
	Feeling Tired, Having No Energy	Dazed or Stunned in appearance	
	Decreased Balance and/or Coordination		

What to do if Someone has a Concussion

If the concussion occurs during an athletic activity, then the individual should be immediately pulled out of play. Staying in the activity with a concussion will make it worse. The rule of thumb if a concussion is suspected is "When in doubt, sit them out". Staying in an activity with a concussion will prolong symptoms and recovery time and set the individual up for a more serious brain injury such as death, second impact syndrome or post-concussive syndrome.

If it is suspected that an individual has a concussion, he/she should be removed from any and all activity and evaluated by a medical professional trained in concussion management. Early evaluation and detection of a concussion can speed the recovery process by ensuring proper management of a concussion. ***WI State Law and Kenosha Unified School District require an immediate removal from activity and medical evaluation of an individual suspected of having a head injury.***

Return to Play from Concussions

WI State Law and Kenosha Unified School District require medical clearance by a physician, physician's assistant or nurse practitioner trained in concussion management before an individual can return to play. Kenosha Unified School District also requires an individual complete a Gradual Return to Play Progression *(as outlined below)* ***before the individual may return to play. This is a standard of care for concussions and other head injuries in the medical field.***

Once an individual is sign and symptoms-free for at least 24 hours and a medical professional trained in concussion management has evaluated and cleared the person, a stepwise return to play progression can be started. Similar to recovering from a bad ankle sprain, gradually introducing activity which increases heart rate to the brain ensure that the brain is able to tolerate the increased activity. If at any point in time during the stepwise progression the person has a return of symptoms, the person should stop the activity and contact the medical professional. It has been shown that by completing a stepwise, gradual return to play progression the likelihood of sustaining another concussion decreases. By performing a gradual return to play progression, the person is preventing further injury to his/her brain.

Following written release by a physician and sign and symptom free for at least 24 hours, students will be required to complete the "Return to Play Progression" under the supervision of a medical professional prior to return to normal unrestricted activities.

Returning to play before an individual is sign and symptom free can result in Post-Concussive Syndrome, 2nd Impact Syndrome, or possibly Death. Returning too soon from a concussion can also leave an individual more susceptible to further concussions. Please make sure the return to play progression is performed under the direction of a medical provider trained in concussion management.

Wisconsin's Sidelined for Safety Act 172

Under this act, at the beginning of the season individuals and parents/guardians of individuals participating in a youth activity or organized athletic activity need to be provided with concussion and head injury information if they wish to participate in that youth athletic activity. "No person may participate in a youth athletic activity unless the person returns the information sheet signed by the person and, if he or she is under the age of 19, by his or her parent or guardian."

Also covered in this act; "An athletic coach, or official involved in a youth athletic activity, or health care provider shall remove a person from the youth athletic activity if the coach, official, or health care provider determines that the person exhibits signs, symptoms, or behavior consistent with a concussion or head injury or the coach, official, or health care provider suspects the person has sustained a concussion or head injury." If an individual is removed from the activity, he/she "may not participate in a youth athletic activity until he or she is evaluated by a health care provider and receives a written clearance to participate in the activity from the health care provider."

For the entire Act 172, please visit the Wisconsin Legislature site at https://docs.legis.wisconsin.gov/2011/related/acts/172

Information from this handout was taken from the following sites:

- Centers for Disease Control and Prevention (http://www.cdc.gov/concussion/sports/index.html)
- WI Sports Concussion Collaborative (http://www.wisportsconcussion.org/)
- WI Interscholastic Athletic Association (http://wiaawi.org/index.php?id=430)
- National Federation of State High School Associations (http://www.nfhslearn.com/)
- Milwaukee Journal Sentinel – Dr. Walters Interview (http://www.jsonline.com/multimedia/video/?bctid=1465030068001)

Emergency/Health Form – Kenosha Unified School District No. 1

(Sport)

YR: ID#

Student Last Name | First Name | Middle Name | Birth date | School | Grade | Parent's Email Address | Cell Phone | Bus#

Student Address (check if new) ☐ | City | State | Zip Code | Home Phone (check if unlisted) ☐ | Family Doctor's Name | Doctor's Phone | Child's Dentist | Dentist Phone

Parent/Guardian Name | Address | City | Home Phone | Cell Phone | Child Lives with Y/N | Employed by | Work Phone & shift hours

Parent/Guardian Name | Address | City | Home Phone | Cell Phone | Child Lives with Y/N | Employed by | Work Phone & shift hours

Please list additional emergency contacts below in the order you wish them to be called:

Name | Address | Home Phone | Cell Phone | Work Phone and Ext | Relationship to Student

Name | Address | Home Phone | Cell Phone | Work Phone and Ext | Relationship to Student

Confidential Health Information If your child's doctor has told you your child has any of the problems noted below, please "**X**" all that apply and answer questions related to problem.

☐ My child has no known health problems ☐ **MY CHILD'S HEALTH CONDITION IS POTENTIALLY LIFE THREATENING**

☐ **Attention Deficit Disorder** with or without hyperactivity ☐ Does your child have a form of Autism? If yes, describe: _____

☐ **Allergies**, Types: ☐ Foods, list foods: _____

☐ Bees, Wasps/Other Insects ☐ Latex/Rubber ☐ Allergies to medications: (List here) _____

☐ Other, please describe _____

☐ **Asthma** or other breathing problems, describe: _____

☐ **Conditions or problems that affect walking or movement**, describe: _____

☐ **Cancer**, Type: _____ Currently in: ☐ Treatment ☐ Remission

☐ **Birth Defects**, list/explain: _____

☐ **Blood Disorder** other than HIV/AIDS (i.e. Sickle Cell), describe: _____ ☐ Elevated Lead Level

☐ **Diabetes** (Circle) **Type 1** or **Type 2** List types of insulin, dose and times taken on back.

☐ **Emotional/Psychological problems**, describe: _____

☐ **Heart Condition**, describe: _____

☐ **Nerve Disorders** other than seizure/epilepsy, describe: _____

☐ **Organ Transplant**, list organ: _____

☐ **Seizure Disorder**, describe type: _____

☐ **Swallowing, Stomach or Intestinal** disorders: _____

☐ **Vision, Hearing, or Speech** problems, describe: _____ ☐ Hearing Aids ☐ Ear Tubes ☐ Glasses

☐ **Other**, describe: _____

***** PLEASE LIST ALL MEDICATIONS AND/OR TREATMENTS ON THE BACK OF THIS FORM *****

CONTINUED ON BACK

STUDENT NAME: _____

MEDICATION (List names of all medications child takes, doses and times given):
Each medication given at school requires written parental consent. Each prescription medication requires a physician's written order and written parental consent. Medication forms may be obtained from the school office.

MEDICATION (name)	DOSE	TIME OR SITUATION (when given)	WHO ADMINISTERS (child/adult)	WHERE KEPT (Home / School / Backpack…)
1.				
2.				
3.				
4.				
5.				
6.				
7.				

I do ☐ I do not ☐ give permission for the principal or his/her designee to contact any of the emergency contacts I have provided if my child becomes ill at school and you cannot reach me by phone.

I do ☐ I do not ☐ give permission to contact the Student's Physician for consultation if needed.

I do ☐ I do not ☐ give permission to share my child's current immunization records and as they are updated in the future with the Wisconsin Immunization Registry (WIR). I understand that I may revoke this consent at any time by sending written notification to the school district. Following the date of revocation, the school district will provide no new records or updates to the WIR.

If a serious illness or accident occurs at school, I understand that my child will be sent by rescue squad to the emergency room. (All expenses charged by the hospital are the responsibility of the Parent/Guardian.)

This form is complete and accurate to the best of my knowledge.

SIGNATURE of Parent/Legal Guardian: _____ **Date:** ____/____/____ **Language spoken at home?** _____