

**REQUEST TO PARTICIPATE IN INTERSCHOLASTIC ATHLETIC
ACTIVITIES AT AN ACCREDITED NONPUBLIC HIGH SCHOOL
BY A STUDENT UNDER COMPETENT PRIVATE INSTRUCTION**

Student's Name: _____ Present Grade level: _____

Student's Address: _____

City, State, Zip: _____

Student's Resident School District: _____

Parent/Guardian Name: _____

Parent/Guardian Address (if different from Student's):

Has student attended or participated for any other high school? _____

If yes, name of school and dates: _____

Is the student dual enrolled in the resident district (for activities or classes) OR is the student enrolled in the resident district's Home School Assistance Program? _____

Interscholastic Athletic Activities Requested: _____

Date of request: _____

Signature of Parent/Guardian: _____

*****For School to Fill Out*****

Name of School: _____

Date of Acceptance: _____

Signature and Title of School Official: _____

NOTES:

1. School keeps one copy, gives one copy to student, sends one copy to the Iowa High School Athletic Association or Iowa Girls High School Athletic Union (depending on gender of student).
2. Student may only participate in interscholastic athletic activities at more than one school during the same school year after serving the period of ineligibility of 90 consecutive school days (absent contemporaneous change of parental residence).
3. Students who participate in interscholastic athletics in this manner are subject to the general transfer rules in 281—IAC chapter 36.
4. Students whose only contact with their resident district is ITED or other assessment are not barred from participation with an accredited nonpublic high school.

APPROVAL GRANTED on _____ (date) by _____ (name and title of official from IHSAA or IGSAU)

**ASSURANCES OF ELIGIBILITY
OF A
STUDENT UNDER COMPETENT PRIVATE INSTRUCTION (CPI)**

Dear Parent or Guardian:

Your child participates on behalf of our high school in interscholastic sports. The eligibility rules of the State Board of Education and State Department of Education require that all of the following conditions be met for a student to be given the opportunity of interscholastic athletic participation:

1. Every student must take at least four courses at all times.
2. Every student must pass all coursework.
3. Every student must be under 20 years of age.
4. Every student must be in good standing with the student's high school.

Please fill out the bottom of this document and return it to _____
no later than _____, _____ Athletic Director
Date

Student's Name: _____

Student's Date of Birth: _____ Present Grade level: _____

Report for grading period ending _____, 201__.

List all courses taken by student for above grading period: _____

By signing below, I certify that the student passed all coursework taken for the above grading period. If the student failed one or more courses, contact

_____ at _____ ASAP. Thank you.

Athletic Director

Phone/e-mail

Signature of Parent/Guardian: _____

Printed name of Parent/Guardian: _____

IOWA ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION

ARTICLE VII 36.14(1) PHYSICAL EXAMINATION.

Every year each student (grades 7-12) shall present to the student's superintendent a certificate signed by a licensed physician and surgeon, osteopathic physician and surgeon, osteopath, advanced registered nurse practitioner (ARNP), physician's assistant or qualified doctor of chiropractic, to the effect that the student has been examined and may safely engage in athletic competition. This certificate of physical examination is valid for the purposes of this rule for one (1) calendar year. A grace period, not to exceed thirty (30) days, is allowed for expired certifications of physical examination.

QUESTIONNAIRE FOR ATHLETIC PARTICIPATION (Please type or neatly print this information)

Student's Name _____ Male ___ Female ___ Date of Birth _____ Grade _____

Home Address (Street, City, Zip) _____ School District _____

Parent's/Guardian's Name _____ Date _____ Phone # _____

Family Physician _____ Phone # _____

HEALTH HISTORY (The following questions should be completed by the student-athlete with the assistance of a parent or guardian. A parent or guardian is required to sign on the other side of this form after the examination.)

Yes	No	Does this student have / ever had?	Yes	No	Does this student have / ever had?
1. _____	_____	Allergies to medication, pollen, stinging insects, food, etc.?	20. _____	_____	Head injury, concussion, unconsciousness?
2. _____	_____	Any illness lasting more than one (1) week?	21. _____	_____	Headache, memory loss, or confusion with contact?
3. _____	_____	Asthma or difficulty breathing during exercise?	22. _____	_____	Numbness, tingling or weakness in arms or legs with contact?
4. _____	_____	Chronic or recurrent illness or injury?	*****		
5. _____	_____	Diabetes?	23. _____	_____	Severe muscle cramps or illness when exercising in the heat?
6. _____	_____	Epilepsy or other seizures?	*****		
7. _____	_____	Eyeglasses or contacts?	24. _____	_____	Fracture, stress fracture or dislocated joint(s)?
8. _____	_____	Herpes or MRSA?	25. _____	_____	Injuries requiring medical treatment?
9. _____	_____	Hospitalizations (Overnight or longer)?	26. _____	_____	Knee injury or surgery?
10. _____	_____	Marfan Syndrome?	27. _____	_____	Neck injury?
11. _____	_____	Missing organ (eye, kidney, testicle)?	28. _____	_____	Orthotics, braces, protective equipment?
12. _____	_____	Mononucleosis or Rheumatic fever?	29. _____	_____	Other serious joint injury?
13. _____	_____	Seizures or frequent headaches?	30. _____	_____	Painful bulge or hernia in the groin area?
14. _____	_____	Surgery?	31. _____	_____	X-rays, MRI, CT scan, physical therapy?

15. _____	_____	Chest pressure, pain, or tightness with exercise?	32. _____	_____	Has a doctor ever denied or restricted your participation in sports for any reason?
16. _____	_____	Excessive shortness of breath with exercise?	33. _____	_____	Do you have any concerns you would like to discuss with your health care provider?
17. _____	_____	Headaches, dizziness or fainting during, or after, exercise?			
18. _____	_____	Heart problems (Racing, skipped beats, murmur, infection, etc.?)			
19. _____	_____	High blood pressure or high cholesterol?			
Yes No Family History:					
34. _____	_____	Does anyone in your family have Marfan syndrome?			
35. _____	_____	Has anyone in your family died of heart problems or any unexpected/unexplained reason before the age of 50?			
36. _____	_____	Does anyone in your family have a heart problem, pacemaker or implanted defibrillator?			
37. _____	_____	Has anyone in your family had unexplained fainting, seizures, or near drowning?			
38. _____	_____	Does anyone in your family have asthma?			
39. _____	_____	Do you or someone in your family have sickle cell trait or disease?			

Use this space to explain any "YES" answers from above (questions #1-38) or to provide any additional information:

40. Are you allergic to any prescription or over-the-counter medications? If yes, list: _____

41. List all medications you are presently taking (including asthma inhalers & EpiPens) and the condition the medication is for:
 A. _____ B. _____ C. _____

42. Year of last known vaccination: Tdap (Tetanus): _____ Meningitis: _____ Influenza: _____

43. What is the most and least you have weighed in the past year? Most _____ Least _____

44. Are you happy with your current weight? Yes _____ No _____ If no, how many pounds would you like to lose or gain?
 Lose _____ Gain _____

FOR FEMALES ONLY:

PHYSICAL EXAMINATION RECORD (To be completed by a licensed medical professional as designated in Article VII 36.14(1). *This evaluation is only to determine readiness for sports participation. It should NOT be used as a substitute for regular health maintenance examinations.*)

Athlete's Name _____ Height _____ Weight _____
 Pulse _____ Blood Pressure _____ / _____ (Repeat, if abnormal _____ / _____) Vision R 20/ _____ L 20/ _____

	NORMAL	ABNORMAL FINDINGS	INITIALS
1. Appearance (esp. Marfan's)			
2. Eyes/Ears/Nose/Throat			
3. Pupil Size (Equal/Unequal)			
4. Mouth & Teeth			
5. Neck			
6. Lymph Nodes			
7. Heart (Standing & Lying)			
8. Pulses (esp. femoral)			
9. Chest & Lungs			
10. Abdomen			
11. Skin			
12. Genitals - Hernia			
13. Musculoskeletal - ROM, strength, etc. (See questions 24-31)			
14. Neurological			

Comments regarding abnormal findings: _____

LICENSED MEDICAL PROFESSIONAL'S ATHLETIC PARTICIPATION RECOMMENDATIONS

 FULL & UNLIMITED PARTICIPATION

 LIMITED PARTICIPATION - May NOT participate in the following (checked):

 Baseball Basketball Bowling Cross Country Football Golf Soccer
 Softball Swimming Tennis Track Volleyball Wrestling

 CLEARANCE PENDING DOCUMENTED FOLLOW UP OF _____

 NOT CLEARED FOR ATHLETIC PARTICIPATION DUE TO _____

Licensed Medical Professional's Name (Printed) _____ Date of PPE _____

Licensed Medical Professional's Signature _____ Phone _____

PARENT'S OR GUARDIAN'S PERMISSION AND RELEASE

I hereby verify the accuracy of the information on the opposite side of this form and give my consent for the above named student to engage in approved athletic activities as a representative of his/her school, except those activities indicated above by the licensed professional. I also give my permission for the team's physician, certified athletic trainer, or other qualified personnel to give first aid treatment to my son or daughter at an athletic event in case of injury/illness and to share necessary information about the injury/illness with appropriate school personnel.

Name of Parent or Guardian (Printed) _____ Signature of Parent of Guardian _____

Address (Street/PO Box, City, State, Zip) _____

HEALTH AND INJURY INFORMATION CARD and CONSENT FOR MEDICAL TREATMENT FORM

(This form is to be completed and kept available for reference wherever competition takes place. Update medical information as necessary.)

Student's Name (Last, First, MI) _____

Age _____ Grade _____ Date of Birth _____ Today's Date _____

Parent's/Guardian's Name _____

Student's Address _____

Parent's/Guardian's Home Phone Number _____

Father's/Guardian's Place of Work _____

Father's/Guardian's Work Phone Number _____

Mother's/Guardian's Place of Work _____

Mother's/Guardian's Work Phone Number _____

In an emergency, when parent's/guardian's cannot be notified, please contact:

_____ Relationship _____ Phone _____

_____ Relationship _____ Phone _____

Family Physician _____ Phone _____

Preferred Hospital _____ Phone _____

Family Dentist _____ Phone _____

Date of last tetanus booster: _____ (month/year)

Do you wear: Glasses _____ yes _____ no / Contacts _____ yes _____ no / Dentures _____ yes _____ no

List any known allergies, drug reactions, or other pertinent medical information. (Diabetes, seizures, history of head injury with unconsciousness or confusion, medications, etc.)

Please note and date any new injury information here: _____

CONSENT FOR MEDICAL TREATMENT

Iowa law requires a parent's, or legal guardian's, written consent before their son or daughter can receive emergency treatment, unless, in the opinion of a physician, the treatment is necessary to prevent death or serious injury.

As the parent(s), or legal guardian(s), of the child named on the front of this card, I (we) authorize emergency medical treatment or hospitalization that is necessary in the event of an accident or illness of my (our) child. I (we) understand that this written consent is given in advance of any specific diagnosis or hospital care. *This written authorization is granted only after a reasonable effort has been made to contact me (us).*

Date _____ Parent's/Guardian's signature

A FACT SHEET FOR PARENTS AND STUDENTS

HEADS UP: Concussion in High School Sports

The Iowa Legislature passed a new law, effective July 1, 2011, regarding students in grades 7 – 12 who participate in extracurricular interscholastic activities. Please note this important information from Iowa Code Section 280.13C, Brain Injury Policies:

- (1) A child must be immediately removed from participation (practice or competition) if his/her coach or a contest official observes signs, symptoms, or behaviors consistent with a concussion or brain injury in an extracurricular interscholastic activity.
- (2) A child may not participate again until a licensed health care provider trained in the evaluation and management of concussions and other brain injuries has evaluated him/her and the student has received written clearance from that person to return to participation.
- (3) Key definitions:
 - “**Licensed health care provider**” means a physician, physician assistant, chiropractor, advanced registered nurse practitioner, nurse, physical therapist, or athletic trainer licensed by a board.
 - “**Extracurricular interscholastic activity**” means any extracurricular interscholastic activity, contest, or practice, including sports, dance, or cheerleading.

What is a concussion?

A concussion is a brain injury. Concussions are caused by a bump, blow, or jolt to the head or body. Even a “ding,” “getting your bell rung,” or what seems to be a mild bump or blow to the head can be serious.

What parents/guardians should do if they think their child has a concussion?

1. **OBEY THE NEW LAW.**
 - a. Keep your child out of participation until s/he is cleared to return by a licensed healthcare provider.
 - b. Seek medical attention right away.
2. Teach your child that it's not smart to play with a concussion.
3. Tell all of your child's coaches and the student's school nurse about ANY concussion.

What are the signs and symptoms of a concussion?

You cannot see a concussion. Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days after the injury. If your teen reports one or more symptoms of concussion listed below, or if you notice the symptoms yourself, keep your teen out of play and seek medical attention right away.

STUDENTS:

If you think you have a concussion:

- **Tell your coaches & parents** – Never ignore a bump or blow to the head, even if you feel fine. Also, tell your coach if you think one of your teammates might have a concussion.
- **Get a medical check-up** – A physician or other licensed health care provider can tell you if you have a concussion, and when it is OK to return to play.
- **Give yourself time to heal** – If you have a concussion, your brain needs time to heal. While your brain is healing, you are much more likely to have another concussion. It is important to rest and not return to play until you get the OK from your health care professional.

IT'S BETTER TO MISS ONE CONTEST THAN THE WHOLE SEASON.

Signs Reported by Students:

- Headache or “pressure” in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Just not “feeling right” or is “feeling down”

PARENTS:

How can you help your child prevent a concussion?

Every sport is different, but there are steps your children can take to protect themselves from concussion and other injuries.

- Make sure they wear the right protective equipment for their activity. It should fit properly, be well maintained, and be worn consistently and correctly.
- Ensure that they follow their coaches' rules for safety and the rules of the sport.
- Encourage them to practice good sportsmanship at all times.

Signs Observed by Parents or Guardians:

- 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

Information on concussions provided by the Centers for Disease Control and Prevention.

For more information visit: www.cdc.gov/Concussion

Student's Signature

Date

Student's Printed Name

Parent's/Guardian's Signature

Date

Student's Grade

Student's School

IMPORTANT: Students participating in interscholastic athletics, cheerleading and dance; and their parents/guardians; must annually sign the acknowledgement below and return it to their school. Students cannot practice or compete in those activities until this form is signed and returned.

We have received the information provided on the concussion fact sheet titled, “HEADS UP: Concussion in High School Sports.”