INSURANCE STATEMENT

It is the policy of Decorah Community Schools that students participating in interscholastic athletics be covered by a private student accident insurance plan OR sign the statement below stating they do not wish to purchase coverage.

(The school district is not forcing anyone to purchase insurance but only to sign a statement that they are aware of the student accident insurance plan offering).

_______I do _______ I do not

wish to have ______________________________ insured under
(Student's name)
the student accident plan offered by the school.

____________________ ____________________
Date Parent Signature

ACKNOWLEDGEMENT OF RISK

We realize there is a possibility that a player may suffer severe injury, including permanent paralysis or death, as a result of participating in athletic activities.

____________________ ____________________
Student's Name (PRINT) Parent/Guardian Name (PRINT)

____________________ ____________________
Student's Signature Parent/Guardian Signature

____________________ ____________________
Date School Name

DECORAH COMMUNITY SCHOOLS

ATHLETIC PHYSICAL & ELIGIBILITY FORM

____
Student Name

__________ ______________
Grade School Year

Directions for completion:

1. Parent and student fill out pages 1, 2, & 4 and sign where designated.
2. Schedule an appointment to enable a licensed professional to complete the top section of page 3.
3. Parent must sign the bottom of page 3 after the physical is complete from the licensed professional.

To have full eligibility, all sections of this form and all signatures must be completed.

Updated May 2020

IOWA ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION

<u>ARTICLE VII 36.14(1) PHYSICAL EXAMINATION.</u> 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, qualified doctor of chiropractic, licensed physician assistant, or advanced registered nurse practitioner, 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 purpose 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____________________________________Date________________ 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 of recurrent illness or injury?	23			Severe muscle cramps or illness when exercising in the heat?
5			Diabetes?	24			Fracture, stress fracture or dislocated joint(s)?
6			Epilepsy or other seizures?	25			Injuries requiring medical treatment?
7			Eyeglasses or contacts?	26			Knee injury or surgery?
8			Herpes or MRSA?	27			Neck injury?
9			Hospitalizations (overnight or longer)?	28			Orthotics, braces, protective equipment?
10			Marfan Syndrome?	29			Other serious joint injury?
11			Missing organ (eye, kidney, testicle)?	30			Painful bulge or hernia in the groin area?
12			Mononucleosis or Rheumatic Fever?	31			X-rays, MRI, CT scan, physical therapy?
13			Seizures or frequent headaches?	32			Has a doctor ever denied or restricted your participation in sports for any reason?
14			Surgery?	33			Do you have any concerns you would like to discuss with your health care provider?
15			Chest pressure, pain, or tightness with exercise?				
16			Excessive shortness of breath with exercise?				
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 dies 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 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 like to lose or gain? Lose__________ Gain __________

FOR FEMALES ONLY:

1. How old were you when you had your first menstrual period?_______________ 2. How many periods have you had in the last 12 months?_____________

PHYSICAL EXAMINATION RECORD:

(to be completed by a licensed medical professional as designated in Article VII 36.14(1).

Athlete Name:____ **Height:**__________ **Weight:**__________

Pulse:____________________ **Blood pressure:**_______/_______ **(repeat, if abnormal** _______/_______**)** **Vision: R 20/**_________ **L 20/**__________

		NORMAL	ABNORMAL FINDINGS	INITIALS
1	Appearance (esp. Marfans)			
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 ATHELTIC PARTICIPATION RECOMMENDATIONS
(Please be precise when indicating at which level the student is cleared to participate.)

1 ☐ **<u>FULL & UNLIMITED PARTICIPATION</u>**

2 ☐ **<u>LIMITED PARTICIPATION</u>** – May **NOT** participate in the following (checked):

☐ Baseball ☐ Basketball ☐ Bowling ☐ Cross Country ☐ Football ☐ Golf ☐ Soccer

☐ Softball ☐ Swimming ☐ Tennis ☐ Track ☐ Volleyball ☐ Wrestling

3 ☐ **<u>CLEARANCE PENDING</u> DOCUMENTED FOLLOW UP OF** ______________________________________

4 ☐ **NOT CLEARED FOR ATHLETIC PARTICIPATION DUE** ______________________________________

____ ____________________

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 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 physican, 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, or student if 18 years of age (PRINTED) **Signature of Parent or Guardian, or student if age 18 years of age**

____ ____________________

Address (Street/PO Box, City, State, Zip) **Phone Number**

This form has been developed with the assistance of the Committee on Sports Medicine of the Iowa Medical Society and has been approved for use by the Iowa Department of Education, Iowa High School Athletic Association, and Iowa Girls High School Athletic Union. Schools are encouraged NOT to change this form from its published format. Additional school forms can be attached to this form. 08/15