Erin School District Athletic Eligibility Form

EVERY SCHOOL YEAR the following items are required to be turned in before a student-athlete may participate in practices or contests. Should you have any questions please contact, Andrew Andress, Athletic Director at andress@erinschool.org or 262-673-3720 ext. 4148.

1. Both sides of this card must be filled out completely and accurately. Parents are responsible for contacting the school with any changes to contact information or their child's physical condition that would be different from this information. A PHYSICAL is only required for every other school year. See the top of the reverse side for date specific information. **TAKE THIS FORM TO THE DOCTOR!!!**
2. Signed Parent & Athlete Concussion form (separate form, can be found on Athletics web page)
3. Pay activity fee (checks payable to Erin School). $50 per sport, per child, ($250 cap per year.)

SCHOOL Year 20______ TO 20______

Student-Athlete Name: ____

Contact Name other than a Parent in case of emergency:_____________________________

Contact Phone numbers for above named person: __________________________________

Additional Name and Number: ____

***** Parents will always be called first. The above information will only be used if a parent is unable to be reached!*****

Parent signature indicates that permission is granted for the above named child to participate in athletics at Erin School. The signature further indicates that all information on this form is accurate and will be kept up to date. Both parent and student signatures indicate that the *Erin School Athletics and Activities Handbook* (can be downloaded or read from the Erin Athletics webpage) have been read and all requirements are agreed to by both parties.

___________________________________ ___________________________________

Parent Signature & Date **Student Signature & Date**

All 3 items as listed above for Eligibility should be completed and returned to Erin School by the 3rd Friday of September for ALL ATHLETES!

Preparticipation Physical Evaluation
CLEARANCE 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 ______ 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).

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 ________________

ERIN SCHOOL
6901 County Trunk O
Hartford, Wisconsin 53027-9798
Phone (262) 673-3720 Fax (262) 673-2659

PARENT & ATHLETE CONCUSSION 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.

For more information regarding concussions, visit the WIAA website at
http://www.wiaawi.org/Health/Concussions.aspx a link can also be found on the Athletics page of our website.

Parent Agreement:

I __________________________________ have read the Parent Concussion and Head Injury Information 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.
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 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 before returning to practice/play.
I understand the possible consequence of returning to practice/play too soon and that my brain needs time to heal.

Athlete Signature____Date____________________

Sport participating in ____

1. Have you ever had a concussion?___________, if yes, how many?___________
   List Concussion Dates (Est) ____

2. Have you ever experienced concussion symptoms? __________ Did you report them __________