ATHLETIC PACKET

School District of Manawa

ST. PAULS STUDENTS - NEW STUDENTS

THIS PACKET INCLUDES:

- ❑ Physical Form - Required every 2 years **OR** Alternate Year Card - If a physical is not required this year. Parents fill this out. Please get your last physical date from your doctor. **ONE OR THE OTHER IS REQUIRED PRIOR TO THE FIRST DAY OF PRACTICE OR ATHLETE MAY NOT PARTICIPATE.

  **ATHLETE AND PARENT SIGNATURE NEEDED*

- ❑ Concussion Form - Only one form is required for the entire year.**THIS IS REQUIRED PRIOR TO THE FIRST DAY OF PRACTICE OR ATHLETE MAY NOT PARTICIPATE.

  **ATHLETE AND PARENT SIGNATURE NEEDED*

- ❑ Emergency Contact Information Form (new student's or current St. Paul's students)

  **PARENT SIGNATURE NEEDED*

- ❑ Parent Impact Permission Form **PARENT SIGNATURE NEEDED*

- ❑ Student Handbooks Co-Curricular Code of Conduct Acknowledgement

  **ATHLETE AND PARENT SIGNATURE NEEDED*

- ❑ Athletic Fee Form

- ❑ Student Accident Insurance Information (Voluntary)

- ❑ R-schools Instructions:

  www.centralwisconsinconference.org

  This online calendar has all sports schedules and will update as contracts are signed. You can go to the website above and click on MANAWA. You can then view daily or weekly schedules. If you click on the advanced view, you can view schedules for next year.

Last Updated: June 18, 2020

PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, or other): _____

List past and current medical conditions. _____

_____

Have you ever had surgery? If yes, list all past surgical procedures. _____

_____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

_____

_____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

_____

_____

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease?		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
FEMALES ONLY	**Yes**	**No**
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "Yes" answers here.

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

1. Consider additional questions on more-sensitive issues.
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

[a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY 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 assigned at birth (F, M or intersex) _____ Grade _____ School _____ City _____

Present Address _____ Telephone _____

❑ **Medically eligible for all sports without restriction**

❑ **Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of**

_____

_____

❑ **Medically eligible for certain sports**

_____

_____

❑ **Not medically eligible pending further evaluation**

❑ **Not medically eligible for any sports**

Recommendations: _____

_____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical exam findings are 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, the physician may rescind the medical eligiblity until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of health care professional (Print/Type) _____

SIGNATURE OF HEALTH CARE PROFESSIONAL (MD OR DO)/PA/APNP*: _____

Clinic Name _____

Address/Clinic _____ City _____ State _____ Zip Code _____

Telephone _____ Date of Examination _____

* **PHYSICIANS** may authorize Nurse Practitioners 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 _____

Medications _____

Other Information _____

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 _____

WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION ALTERNATE YEAR ATHLETIC PERMIT CARD

Physical Date _____ SCHOOL YEAR 20_____ - 20_____

NAME _____ GRADE _____ DATE OF BIRTH _____
Last First Middle Initial

Present Address _____ Telephone _____

Parents' Place of Employment _____

Family Physician _____ Family Dentist _____

Name of Private Insurance Carrier _____ Telephone _____

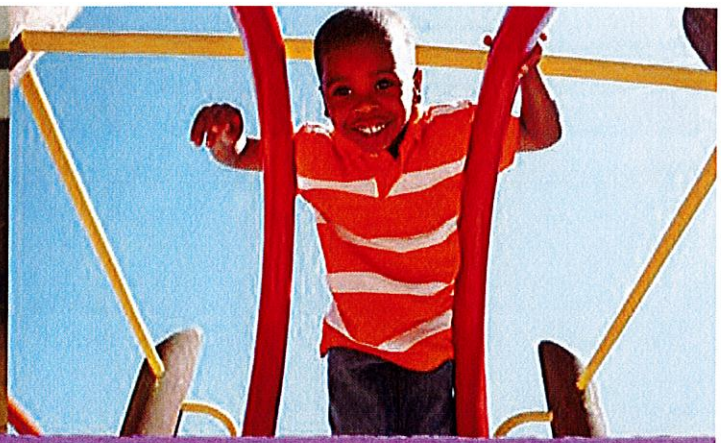
Subscriber Member Name (Primary Insured) _____

1. I hereby give my permission for the above named student to practice and compete and represent the school in WIAA approved sports.
2. I also attest to the fact that the above named student has had no injury or illness serious enough to warrant a medical evaluation prior to participating this school year.
3. 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.
4. It is recommended that information regarding your child's allergies and prescribed medication be made available.

PARENT: If there is any question that this student may not be qualified for athletic competition without, at least, a partial re-evaluation, contact your medical advisor before signing card.

SIGNATURE OF PARENT _____ DATE _____

ALL STUDENTS PARTICIPATING IN INTERSCHOLASTIC ATHLETICS MUST HAVE THIS ALTERNATE YEAR CARD ON FILE AT THEIR SCHOOL PRIOR TO PRACTICE OR PARTICIPATION



KNOW YOUR CONCUSSION ABCs

Assess the situation | Be alert for signs and symptoms | Contact a health care provider

Wisconsin Fact Sheet for Athletes

What is a concussion?

A concussion is a type of brain injury that changes the way the brain normally works. A concussion is caused by a bump, blow, or jolt to the head. Concussions can also occur from a blow to the body that causes the head and brain to move rapidly back and forth. Even what seems to be a mild bump to the head can be serious. Concussions can occur during practices or games in any sport or recreational activity.

What are the signs and symptoms of a concussion?

Unlike a broken arm, you can't see a concussion. Most concussions occur without loss of consciousness. Signs and symptoms of concussion can show up right after an injury or may not appear or be noticed until hours or days after the injury. It is important to watch for changes in how you are feeling, if symptoms are getting worse, or if you just "don't feel right." If you think you or a teammate may have a concussion, it is important to tell someone.

COMMON SYMPTOMS OF A CONCUSSION:

Tell someone if you see a teammate with any of these symptoms:

- Appears dazed or stunned
- Forgets sports plays
- Is confused about assignment or position
- Moves clumsily
- Answers questions slowly
- Repeats questions
- Can't recall events prior to the hit, bump, or fall
- Can't recall events after the hit, bump, or fall
- Loses consciousness (even briefly)
- Shows behavior or personality changes

Tell someone if <u>you</u> feel any of the following:

Thinking/Remembering:

- Difficulty thinking clearly
- Difficulty concentrating or remembering
- Feeling more slowed down
- Feeling sluggish, hazy, foggy, or groggy

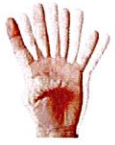
Physical:

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Fatigue or feeling tired
- Blurry or double vision
- Sensitivity to light or noise
- Numbness or tingling
- Does not "feel right"

Emotional:

- Irritable
- Sad
- More emotional than usual
- Nervous

Changes in your normal sleep patterns.



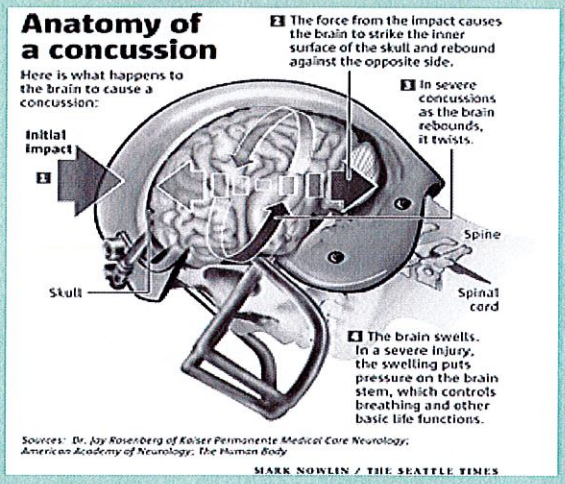
Materials adapted from the U.S. Department of Health and Human Services Centers for Disease Control and Prevention

WISCONSIN DEPARTMENT OF PUBLIC INSTRUCTION

*Wear the proper equipment for each sport and make sure it fits well.

*Follow the rules of the sport and the coach's rule for safety.

*Use proper technique.



If you have a suspected concussion, you should NEVER return to sports or recreational activities on the same day the injury occurred. You should not return to activities until you are symptom-free and a health care provider experienced in managing concussion provides written clearance allowing return to activity. This means, until permitted, not returning to:

- Physical Education (PE) class,
- Sports conditioning, weight lifting, practices and games, or
- Physical activity at recess.

What should you do if you think you have a concussion?

1. Tell your coaches and parents right away. Never ignore a bump or blow to the head even if you feel fine. If you experience symptoms of a concussion, you should immediately remove yourself from practice/play. Tell your coach right away if you think you or one of your teammates might have a concussion.
2. Get evaluated by a health care provider. A health care provider experienced in evaluating for concussion can determine if you have a concussion, help guide management and safe return to normal activities, including school (concentration and learning) and physical activity. If you have been removed from a youth athletic activity because of a suspected or confirmed concussion or head injury you may not participate again until evaluated by a health care provider and you receive written clearance to return to activity. You must provide this written clearance to your coach.
3. Give yourself time to get better. If you have had a concussion, your brain needs to time to heal. While your brain is still healing, you are much more likely to have a repeat concussion. It is important to rest until you receive written clearance from a health care provider to return to practice and play.

Why should you tell someone about your symptoms?

1. Your chances of sustaining a life altering injury are greatly increased if you aren't fully recovered from a concussion or head injury.
2. Practicing/playing with concussion symptoms can prolong your recovery.
3. Practicing/playing with a concussion can increase your chances of getting another concussion.
4. Telling someone could save your life or the life of a teammate!

Tell your teachers

Tell your teachers if you have suffered a concussion or head injury. Concussions often impair school performance. In order to properly rest, many students often need to miss a few days of school immediately following a concussion. When you return to school after a concussion you may need to:

- Take rest breaks as needed,
- Spend fewer hours at school,
- Have more time allowed to take tests or complete assignments,
- Suspend your physical activity (PE class and/or recess)
- Suspend your extracurricular activities (band, choir, dance, etc)
- Reduce time spent reading, writing, or on the computer.

To learn more about concussions, go to:
www.cdc.gov/Concussion; www.wiaawi.org; www.nfhs.org

ATHLETIC PACKET

School District of Manawa

CONCUSSION FACTS ACKNOWLEDGEMENT

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.

A concussion is a type of traumatic brain injury. Concussions occur when there is a forceful blow to the head or body that results in rapid movement of the head and causes any change in behavior, thinking, or physical functioning. Concussions are not limited to situations involving loss of consciousness. Some symptoms of a concussion include headache, nausea, confusion, memory difficulties, dizziness, blurred vision, anxiety, difficulty concentrating, and difficulty sleeping.

Each school year, students/parents shall be provided with an information sheet regarding concussion and head injury. If a student is going to participate in an activity where a concussive event may occur, the appropriate release must be signed at least once per school year.

Further, pursuant to AG 5340A – Student Accident/Illness/Concussion, parents who inform coaches and teachers that their child is being treated by a healthcare professional for a concussion must provide written clearance from that healthcare professional for full or limited participation in class, practice, activity, or competition. Prior to receiving written clearance from a healthcare professional, students who have sustained a concussion may not participate in any school-related physical activities.

Guardian and Student Agreement

- I have read the Wisconsin Concussion Fact Sheet for Athletes document and understand what a concussion is and how it may be caused.
- I understand the importance of reporting a suspected concussion and that it is my responsibility to seek medical treatment.
- I understand that the student must be removed from practice/play and cannot return until provided 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.

Date _____

Student Signature:_____

Parent/Guardian Signature:_____

MANAWA SCHOOL DISTRICT 2020 - 2021 EMERGENCY CONSENT FORM

Student's full name: Last _____ First _____ M.I. _____

Date of birth _____ Male _____ Female _____ Grade _____

Address where student lives _____
(address) (city) (state) (zip)

Student mailing address _____
(address) (city) (state) (zip)

Mother or Guardian _____

Home Address _____
(address) (city) (state) (zip)

Primary Phone Number _____ **Cell Phone Number** _____
(this will be the number called with school alerts)

Business _____
(name) (address) (phone)

Father or Guardian _____

Home Address _____
(address) (city) (state) (zip)

Primary Phone Number _____ **Cell Phone Number** _____
(this will be the number called with school alerts)

Business _____
(name) (address) (phone)

Custody (who has custody of the child?) Circle one: Mother Father Both Guardian Court

If school cannot contact parent, name a friend or relative in the area who may be called for illness or emergency.

First Choice _____
(name) (relationship) (phone)

Second Choice _____
(name) (relationship) (phone)

Health Alert: _____Asthma (carries inhaler) _____Seizure Disorder _____Diabetic _____Allergy _____

Doctor _____ **Dentist** _____
(name) (phone) (name) (phone)

Hospital _____
(name) (phone)

Pre-existing medical condition? _____ **Currently on any medications?** _____
(name)

Has you child been diagnosed with a condition which could impair his/her ability to learn? _____YES _____NO

Is there anything you would like to discuss with the school nurse? _____YES _____NO

Health Insurance Co. _____

Subscriber Name _____ **Policy No.** _____ **Group No.** _____

In the event of a medical emergency, during my absence, I hereby give consent for treatment, administration of anesthesia, and surgical intervention for my (son / daughter) _____ as deemed necessary by the attending physician. This consent is extended to the physician, nursing staff, and hospital and will remain in effect until revoked in writing by the undersigned. The parent's recommendation will be respected as far as possible. I understand that in the final disposition of an emergency, the judgment of school authorities and medical staff will prevail. Anytime the above information changed, I will notify school. Completed information to be confidentially shared with school staff as medically indicated.

Signature of Parent or Guardian _____ Date _____

ATHLETIC PACKET

School District of Manawa

CONSENT FOR COGNITIVE TESTING AND RELEASE OF INFORMATION

I give permission for (name of student): _____

(Student's date of birth): _____

To have Baseline ImPACT (Immediate Baseline Assessment and Cognitive Testing) administered at the School District of Manawa, I understand that my student may need to be tested more than once, depending upon the results of the test, as compared to my student's baseline test, which is on file at the School District of Manawa. I understand that there is no charge for this testing.

ImPACT testing is not mandatory to participate in athletics. It is recommended Baseline ImPACT testing is completed as early as possible in the athletic season. It is the students' responsibility to arrange a time with their coach to complete testing.

The School District of Manawa may release the ImPACT results to my student's primary physician, neurologist, or other treating physician, as indicated below.

I understand that general information about the test data may be provided to my student's guidance counselor and teachers, for the purpose of providing temporary academic modifications, if necessary.

PRINT Name of Parent/Guardian
SIGNATURE of Parent/Guardian
Date:
Parent/Guardian Preferred Phone:
PLEASE PRINT THE FOLLOWING INFORMATION
Name of Doctor:
Name of Practice or Group:
Phone Number:
Student's Home Address:

ATHLETIC PACKET

School District of Manawa

MANAWA

Student/Parent/Guardian Handbook,
Co-Curricular Code of Conduct Acknowledgement

CODE OF CONDUCT Participants/athletes are reminded that they represent the school both at athletic contests and elsewhere. All participants/athletes are expected to follow all school rules and to display high standards of behavior, including good sportsmanship, respect for others, and use of appropriate language and dress at all times. Participants/athletes must refrain from any conduct at any time that would reflect unsatisfactorily on him or her or the school. This code applies to all students on a year-round basis. This code applies to all school activities, both curricular and extracurricular, that occur outside of the normal school day. Conduct that would reflect unsatisfactorily on a participant/athlete or on the school includes, but is not limited to, the following: Any crime dealing with, but not limited to, sexual behavior, vandalism or property damage, theft. Possession, use, sale or purchase of any controlled substance/intoxicant or drug paraphernalia. Controlled substances/intoxicants include but are not limited to: anabolic steroids or prescribed medications used in a manner other than that for which they were prescribed. Purchase use or possession of tobacco products or E-cigarettes or anything that resembles them. The possession of any weapon or look-alike weapons. Hosting, sponsoring, or organizing a party/gathering at which alcohol or drugs are being used, consumed or offered. Being in the presence of others who are illegally possessing or using alcohol or controlled substances. It is the expectation of this code that a student will leave the premises the moment they become aware of others illegally possessing and/or using alcohol or controlled substances, even if the student is not consuming or using the illegal substances.

If a student records more than 10 tardies in a semester, the student shall serve a code of conduct violation. If a student accumulates 5 or more referrals in a semester, the student shall serve a code of conduct violation. Code violations may be presented, in writing, to the Administration by any staff member, liaison officer and/or credible person who has knowledge of a possible infraction. A confidential complaint will be investigated to the extent possible. Violations of the school rules/conduct shall also be a violation of the Extra-Curricular Code and the participant/athlete is to be disciplined accordingly as established by the principal, athletic director, and/or advisor.

I have been given the opportunity to view and/or obtain any of the above information for review. My student and I have read and understand the information contained in each section. By signing below, we agree to follow the rules and guidelines within the Student/Parent/Guardian Handbook and Code of Conduct. I am aware that the Handbook and the Code of Conduct are available on the School District of Manawa website, in each student's offline Google Drive folder, and available in paper form in the school's office.

Date _____

Student Signature:_____

Last Updated: June 18, 2020

ATHLETIC PACKET

School District of Manawa

ATHLETIC PARTICIPATION FEES

Name of Student Athlete and Grade:_____

Athletic fees are waived for families that qualify for the Free or Reduced Lunch Program. To apply for the Free or Reduced Lunch Program, please contact the Food Service Manager at 596-5834. [TBD: FR qualification program language] Sports fees should be paid prior to the first game.

Anticipated Athletic Involvement: (Fill in all that apply)

MIDDLE SCHOOL ATHLETIC PARTICIPATION FEES		
☐ Girls Volleyball $15	☐ Boys Football $15	☐ Cross Country $15
☐ Girls Basketball $15	☐ Boys Basketball $15	☐ Track & Field $15
Wrestling Club N/C	**TOTAL FEES $**	
Maximum fees collected for middle school athletics per student per year is **$30.00** or **$150.00** per family per year. Checks should be payable to the School District of Manawa.		

HIGH SCHOOL ATHLETIC PARTICIPATION FEES		
☐ Girls Volleyball $30	☐ Boys Football $30	☐ Cross Country $30
☐ Girls Basketball $30	☐ Boys Basketball $30	☐ Wrestling $30
☐ Girls Softball $30	☐ Boys Baseball $30	☐ Co-Ed Golf $30
☐ Track & Field $30	**TOTAL FEES $**	
Maximum fees collected for high school athletics per student per year is **$75.00** or **$150.00** per family per year. Checks should be payable to the School District of Manawa.		

FOR OFFICE USE ONLY ☐ PAID by CASH/CHECK#_____ DATE _____ ☐ Waiver INITIALS_____

Last Updated: July 16, 2019