ATHLETIC PACKET

School District of Manawa

THIS PACKET INCLUDES:

- ❏ Physical Form - Required every 2 years **OR** Alternate Year Card - If a physical is not required this year. Parent fills 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*

- ❏ WIAA Eligibility (Grades 9-12 ONLY) **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: July 16, 2019

PREPARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

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

Signature of athlete _____ Signature of parent/guardian _____ Date _____

PREPARTICIPATION PHYSICAL EVALUATION
THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

1. Type of disability
2. Date of disability
3. Classification (if available)
4. Cause of disability (birth, disease, accident/trauma, other)
5. List the sports you are interested in playing

	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

_____

_____

_____

_____

_____

Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

_____

_____

_____

_____

_____

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

Signature of athlete _____ Signature of parent/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, 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 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 (questions 5–14).

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any 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) _____ Date _____

Address _____ Phone _____

Signature of physician _____ MD or DO/PA/APNP

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)/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 _____

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 _____

WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION ALTERNATE YEAR ATHLETIC PERMIT CARD

SCHOOL YEAR 20_____ - 20_____

Physical Date _____

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

WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION ALTERNATE YEAR ATHLETIC PERMIT CARD

SCHOOL YEAR 20_____ - 20_____

Physical Date _____

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

WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION ALTERNATE YEAR ATHLETIC PERMIT CARD

SCHOOL YEAR 20_____ - 20_____

Physical Date _____

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

EMERGENCY CONSENT FORM

New Athletic Students

School District of Manawa

STUDENT INFORMATION

STUDENT NAME (LAST, FIRST) **PREFERRED NAME** **GRADE**		BIRTHDATE (MM/DD/YY) ____/_____/_____ GENDER M F
HOME ADDRESS	HOME TELEPHONE ( )	CELL PHONE ( )
PARENT/LEGAL GUARDIAN INFORMATION		
PARENT OR LEGAL GUARDIAN NAME (LAST, FIRST)		EMAIL ADDRESS
ADDRESS IF DIFFERENT FROM STUDENT		Is there a court order dealing with custody? ☐ Yes ☐ No If yes, copy of court order needed.
HOME PHONE ( )	WORK PHONE ( )	CELL PHONE ( )
EMERGENCY CONTACT(S) NOT LISTED ABOVE		
CONTACT 1: (LAST NAME, FIRST NAME) ☐ Student may be released to this contact.		RELATIONSHIP TO STUDENT
HOME PHONE ( )	WORK PHONE ( )	CELL PHONE ( )
CONTACT 2: (LAST NAME, FIRST NAME) ☐ Student may be released to this contact.		RELATIONSHIP TO STUDENT
HOME PHONE ( )	WORK PHONE ( )	CELL PHONE ( )
PHYSICIAN/INSURANCE INFORMATION		
STUDENT'S PHYSICIAN NAME		TELEPHONE NUMBER ( )
DOES YOUR STUDENT HAVE HEALTH INSURANCE? ☐ Yes ☐ No Name of Health Insurance Provider:		HEALTH INS. PROVIDER NUMBER
HOSPITAL:		
STUDENT'S DENTIST NAME		TELEPHONE NUMBER ( )
DOES YOUR STUDENT HAVE DENTAL INSURANCE? ☐ Yes ☐ No Name of Health Insurance Provider:		DENTAL INS. PROVIDER NUMBER

Office use only - address has been verified. Initial here _____

Continue on back page

EMERGENCY CONSENT FORM

New Athletic Students

School District of Manawa

STUDENT MEDICAL INFORMATION

Please indicate any current health condition(s) that may require attention while attending practices and athletic events.

☐ ADD/ADHD WITH MEDICATION	☐ ALLERGY TO FOOD List allergens:_____ ☐ Medication with school clinic ☐ NO medication with school clinic	☐ ALLERGY (OTHER) List allergens:_____ ☐ Medication with school clinic ☐ NO medication with school clinic
☐ ALLERGY TO MEDICATIONS List allergens:_____	☐ ASTHMA ☐ Medication with school clinic ☐ NO medication with school clinic	☐ SEIZURES ☐ Medication with school clinic ☐ NO medication with school clinic
☐ DIABETES TYPE 1 ☐ Insulin & CGM ☐ Insulin Only ☐ CGM Only ☐ No Insulin or CGM	☐ DIABETES TYPE 2	☐ OTHER HEALTH CONDITIONS ☐ Medication with school clinic ☐ NO medication with school clinic

Circle any condition your student has a history of.

Skin Condition/Rash	Anxiety/Depression	Heart Failure/Condition	Diet Restriction
Phenylketornuria (PKU)	Bowel/Bladder Issues	Frequent Stomach Aches	Cancer
Orthopedic (Bone & Muscle Issues)	Frequent Ear Infections	Fractures/Broken Bones	Frequent Headaches
Previous Concussion			

Any additional information:

_____

_____

A SEPARATE MEDICATION AUTHORIZATION FORM MUST BE COMPLETED FOR ANY MEDICATION(S) TO BE GIVEN.

In the event of a medical emergency, during my absence, I hereby give consent for treatment, administration of anesthesia, and surgical intervention for my student 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 judgement of school authorities and medical staff will prevail. Anytime the above information is changed, I will notify school. Completed information to be confidentially shared with school staff as medically indicated.

Singature of Parent/Guardian _____ Date _____

Office use only - address has been verified. Initial here _____

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KNOW YOUR CONCUSSION ABCs

Assess the situation

Be alert for signs and symptoms

Contact a health care provider

Wisconsin Concussion 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.

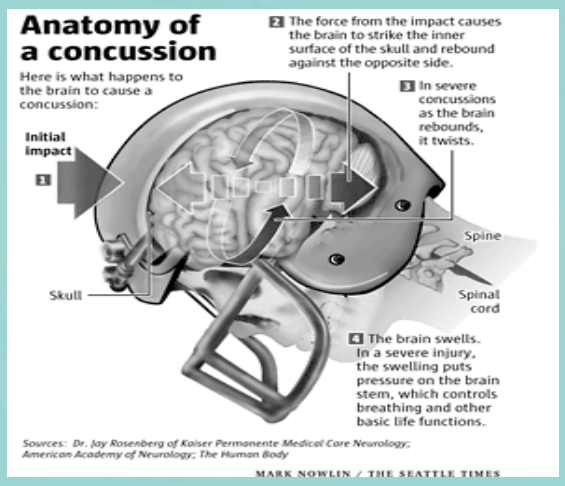
Materials adapted from the U.S. Department of Health and Human Services Centers for Disease Control and Prevention

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.wiawi.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:_____

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. Students who knowingly or unknowingly attend a party/gathering where alcohol is being used illegally or drugs are present, are expected to remove themselves immediately from the residence. Students are encouraged to report the scenario to a school administrator immediately. 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:_____

Parent/Guardian Signature:_____

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

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]

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 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 School District of Manawa.		

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

Last Updated: July 16, 2019