STALLION ATHLETICS
ATHLETIC ELIGIBILITY CHECK LIST
ATHLETIC DIRECTOR: STEVEN SCHIESEL

(586) 698-4622 sschiesel@wcskids.net
Twitter: @SHHS_BlacknGold
Facebook: SHHS Stallion Athletics
Big Teams Webpage: https://shstallions.com/

To participate in athletics at Sterling Heights High School the information and check list provided below must be completed and verified by Mr. Schiesel before you can condition, tryout, practice, or compete for any team. Your stamped Medical Cards will serve as your permission slip to participate for your coach.

Name:__________________________________ **Grade:**________

Sport(s)________________________________ **Birthdate:**________

Check List:

Completed Physical after **April 15 (No Blank Areas)** ________

Two Completed WCS Medical Treatment Cards ________

Completed WCS Handbook/Contract (**Booklet**) ________

Passing 4 out of 6 classes from previous semester ________

Athletes Signature______________________________ **Date:**________

Mr. Schiesels Signature__________________________ **Date:**________

MEDICAL HISTORY: Completed by Parent or Guardian or 18-Year-Old

Student Name: ______________________ Date of Birth: ______________

Doctor: ______________ Doctor's Phone: ______________ Date of Exam: ______________

GENERAL QUESTIONS	Y	N
Has a doctor ever denied or restricted your participation in sports for any reason?		
Do you have any ongoing medical conditions? If so, please identify below:		
☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections ☐ Other:		
Have you ever spent the night in the hospital or have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Y**	**N**
Have you ever passed out or nearly passed out DURING or AFTER exercise?		
Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
Does your heart ever race or skip beats (irregular beats) during exercise?		
Has a doctor ever told you that you have any heart problems? Check all that apply:		
☐ High blood pressure ☐ Heart murmur ☐ Heart infection ☐ High cholesterol		
☐ Kawasaki disease ☐ Other:		
Has a doctor ordered a test for your heart? (example, ECG/EKG, echocardiogram)		
Do you get lightheaded or feel more short of breath than expected during exercise?		
Do you have a history of seizure disorder or had an unexplained seizure?		
Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Y**	**N**
Has anyone in your family had unexplained fainting, unexplained seizures or near drowning?		
Does anyone in your family have a heart problem, pacemaker or implanted defibrillator?		
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)?		
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?		
BONE AND JOINT QUESTIONS	**Y**	**N**
Have you ever had an injury to a bone, muscle, ligament or tendon that caused you to miss a practice or a game?		
Have you ever had any broken or fractured bones, dislocated joints or stress fracture?		
Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast or crutches?		
Do you regularly use a brace, orthotics or other assistive device?		
Do you have a bone, muscle or joint injury that bothers you?		
Do any of your joints become painful, swollen, feel warm or look red?		
Do you have any history of juvenile arthritis or connective tissue disease?		
Have you ever had an x-ray for neck instability or atlantoaxial instability (Down syndrome or dwarfism)?		

MEDICAL QUESTIONS	Y	N
Do you cough, wheeze or have difficulty breathing during or after exercise?		
Have you ever used an inhaler or taken asthma medicine?		
Is there anyone in your family who has asthma?		
Were you born without, or missing a kidney, eye, testicle (males), spleen or any other organ?		
Do you have groin pain or a painful bulge or hernia in the groin area?		
Have you had infectious mononucleosis (mono) within the last month?		
Do you have any rashes, pressure sores or other skin problems?		
Have you had a herpes or MRSA skin infection?		
Do you have headaches or get frequent muscle cramps when exercising?		
Have you ever become ill while exercising in the heat?		
Do you or someone in your family have sickle cell trait or disease?		
Have you had any problems with your eyes or vision or any eye injuries?		
Do you wear glasses or contact lenses?		
Do you wear protective eyewear such as goggles or a face shield?		
Immunization History: Are you missing any recommended vaccines?		
Do you have any allergies?		
Have you ever had a head injury or concussion?		
Do you have any concerns that you would like to discuss with a doctor?		
Have you ever received a blow to the head that caused confusion, prolonged headache or memory problems?		
Have you ever had numbness, tingling, weakness or inability to move your arms or legs after being hit or falling?		
Have you ever had an eating disorder?		
Do you worry about your weight?		
Are you trying to or has anyone recommended that you gain or lose weight?		
Are you on a special diet or do you avoid certain types of foods?		
FEMALES ONLY (Optional)	**Y**	**N**
Have you ever had a menstrual period?		
How old were you when you had your first menstrual period?		
How many periods have you had in the last 12 months?		

CURRENT YEAR PHYSICAL = GIVEN ON OR AFTER APRIL 15 OF THE PREVIOUS SCHOOL YEAR

PHYSICAL EXAMINATION & MEDICAL CLEARANCE: Completed by MD, DO, PA or NP - RETURN DIRECTLY TO PATIENT

EXAMINATION: Height: Weight: ☐ Male ☐ Female BP: / Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N

MEDICAL	NORMAL	ABNORMAL
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: Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (PMI)		
Pulses: Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin: HSV: Lesions suggestive of MRSA, tinea corporis		
Neurologic		

MUSCULOSKELETAL	NORMAL	ABNORMAL
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		
Functional Duck Walk		

RECOMMENDATIONS: ______________________

I certify that I have examined the above student and recommend him/her as being able to compete in supervised athletic activities NOT crossed out below.

BASEBALL – BASKETBALL – BOWLING – COMPETITIVE CHEER – CROSS COUNTRY – FOOTBALL – GOLF – GYMNASTICS – ICE HOCKEY
LACROSSE – SKIING – SOCCER – SOFTBALL – SWIMMING/DIVING – TENNIS – TRACK & FIELD – VOLLEYBALL – WRESTLING

EXAMINER

Name of Examiner (print/type): ______________________ Date: ______________

Signature of Examiner: ______________________ (Check One): ☐ MD ☐ DO ☐ PA ☐ NP

(DETACH HERE IF NEEDED TO ACCOMPANY STUDENT-ATHLETE)

EMERGENCY INFORMATION: COMPLETED BY PARENT or GUARDIAN or 18-YEAR-OLD

Student: ______________ Grade: ______ Doctor: ______________ Phone: (______) ______________

IN EMERGENCY (1): ______________ Home #: (______) ______________ Cell #: (______) ______________

IN EMERGENCY (2): ______________ Home #: (______) ______________ Cell #: (______) ______________

Drug Reactions: ______________ Current Medications: ______________

Allergies: ______________

PRE-PARTICIPATION PHYSICAL - CONSENT - INSURANCE

Shaded headline areas are to be completed by student, parent/guardian or 18-year-old

There are **FOUR** (4) signatures on this page ④ to be completed by student, parent/guardian and/or 18-year-old

A CURRENT-YEAR PHYSICAL IS ONE GIVEN ON OR AFTER APRIL 15 OF THE PREVIOUS SCHOOL YEAR

Student Name: ____
LAST FIRST MIDDLE INITIAL

Student Address: ____
STREET CITY ZIP

Gender: ☐ M ☐ F Age: _____ Date of Birth: ____________ Place of Birth (City/State): ____________

School: ______________________ Circle Grade: 6 7 8 9 10 11 12

Father/Guardian Name: ____

Phone (home): ____________ (work): ____________ (cell): ____________

Mother/Guardian Name: ____

Phone (home): ____________ (work): ____________ (cell): ____________

Email Address: Parent/Guardian/18-Year-Old: ____

STUDENT PARTICIPATION & PARENT or GUARDIAN or 18-YEAR-OLD CONSENT

The information submitted herein is truthful to the best of my knowledge. By my/my child's signature below, **I/we acknowledge that I/we have received concussion educational information that meets Michigan Department of Health and Human Services and MHSAA requirements.**

Further, in consideration of my/my child's participation in MHSAA-sponsored athletics, I/we do hereby agree, understand, appreciate, and acknowledge: **that participation in such athletics is purely voluntary; that such activities involve physical exertion and contact and that there is inherent risk of personal injury associated with participation in such activities, which risk I/we assume;** and that I/we agree to, and hereby waive any and all claims, suits, losses, actions, or causes of action against the MHSAA, its members, officers, representatives, committee members, employees, agents, attorneys, insurers, volunteers, and affiliates based on any injury to me, my child, or any person, whether because of inherent risk, accident, negligence, or otherwise, during or arising in any way from my/my child's participation in an MHSAA-sponsored sport.

I/we understand that I am/we are expected to adhere firmly to all established athletic policies of my school district and the MHSAA. I/we hereby give my consent for the above student to engage in interscholastic athletics and for the disclosure to the MHSAA of information otherwise protected by FERPA and HIPAA for the purpose of determining eligibility for interscholastic athletics. My child has my permission to accompany the team as a member on its out-of-town trips.

① Signature of **STUDENT**: ______________________________ Date: ____________

② Signature of **PARENT** or **GUARDIAN** or **18-YEAR-OLD**: ______________________________ Date: ____________

INSURANCE STATEMENT

Our son/daughter will comply with the specific insurance regulations of the school district.

The student-athlete has health insurance: ☐ YES ☐ NO

If YES, Family Insurance Co: ____________________ Insurance ID #: ____________________

Additionally, I hereby state that, to the best of my knowledge, my answers to the medical history questions (see reverse) are complete and correct.

③ Signature of **PARENT** or **GUARDIAN** or **18-YEAR-OLD**: ______________________________ Date: ____________

- - - - - - - - - - (DETACH HERE IF NEEDED TO ACCOMPANY STUDENT-ATHLETE) - - - - - - - - - -

MEDICAL TREATMENT CONSENT: COMPLETED BY PARENT or GUARDIAN or 18-YEAR-OLD

I, ____________________, an 18-year-old, or the parent or guardian of ____________________, recognize that as a result of athletic participation, medical treatment on an emergency basis may be necessary, and further recognize that school personnel may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the then-existing circumstances and to assume the expenses of such care.

④ Signature of **PARENT** or **GUARDIAN** or **18-YEAR-OLD**: ______________________________ Date: ____________

Warren
Consolidated
Schools

Medical Treatment Authorization

Form# 2011

Name:________________________ Birthdate:________ Home Telephone:____________

Parent (Guardian):____________________ Address:________________________

Father's Phone (Work):________________ Mother's Phone (Work):________________

Person to Notify if Parent Cannot Be Reached - Name:________________________

Address:________________ Phone:____________ Relation:____________

PURPOSE OF THIS CARD: To enable parents or guardians to authorize the provision of emergency treatment for minors who become ill or injured while under school authority when parents or guardians cannot be reached. In the event of an emergency requiring medical attention, I hereby grant my permission to the team physician, trainer or coach to administer first aid to my son/daughter______________________________ Yes:_____ No:_____

In the event of an emergency requiring further medical attention, I hereby grant my permission to ________________(family doctor) at ________________(preferred hospital) or (if not possible) to attending physician at the hospital designated by the school staff to attend to my son/daughter________________________. Yes:_____ No:_____

I expect every effort will be made to contact me in order to receive my specific authorization before any major medical treatment or hospitalization is undertaken.

Date:______________ Signature:________________________________

HEALTH HISTORY

Family Doctor:________________ Phone:____________ Hospital:____________

Insurance Company:________________ Insurance Contract Number:________________

Date of Last Physical:________________ Date of Last Tetanus Shot:________________

Medical History:	YES	NO	
Heart Condition:	____	____	If So Explain: ________________
Epilepsy:	____	____	________________
Diabetes:	____	____	If So Please State: ________________
Asthma:	____	____	If So Please State: ________________
Other Condition:	____	____	If So Please State: ________________
Wear Contacts or Glasses:	____	____	If So Please Indicate Which: ________________
Allergic To Any Medication:	____	____	If So Please List: ________________

PLEASE FILL CARD OUT COMPLETE AND SIGN IT. PLEASE NOTIFY THE SCHOOL IF ANY OF THE INFORMATION (Above or on the other side) CHANGES DURING THE SCHOOL YEAR.

HEALTH HISTORY

Family Doctor:________________ Phone:____________ Hospital:____________

Insurance Company:________________ Insurance Contract Number:________________

Date of Last Physical:________________ Date of Last Tetanus Shot:________________

Medical History:	YES	NO		
Heart Condition:	____	____	If So Explain:	____________
Epilepsy:	____	____		____________
Diabetes:	____	____	If So Please State:	____________
Asthma:	____	____	If So Please State:	____________
Other Condition:	____	____	If So Please State:	____________
Wear Contacts or Glasses:	____	____	If So Please Indicate Which:	____________
Allergic To Any Medication:	____	____	If So Please List:	____________

PLEASE FILL CARD OUT COMPLETE AND SIGN IT. PLEASE NOTIFY THE SCHOOL IF ANY OF THE INFORMATION (Above or on the other side) CHANGES DURING THE SCHOOL YEAR.

Warren Consolidated Schools

Medical Treatment Authorization

Form# 2011

Name:________________ Birthdate:________ Home Telephone:____________

Parent (Guardian):________________ Address:________________

Father's Phone (Work):____________ Mother's Phone (Work):____________

Person to Notify if Parent Cannot Be Reached - Name:________________

Address:________________ Phone:____________ Relation:____________

PURPOSE OF THIS CARD: To enable parents or guardians to authorize the provision of emergency treatment for minors who become ill or injured while under school authority when parents or guardians cannot be reached. In the event of an emergency requiring medical attention, I hereby grant my permission to the team physician, trainer or coach to administer first aid to my son/daughter________________ Yes:_____ No:_____

In the event of an emergency requiring further medical attention, I hereby grant my permission to ____________(family doctor) at ____________(preferred hospital) or (if not possible) to attending physician at the hospital designated by the school staff to attend to my son/daughter________________. Yes:_____ No:_____

I expect every effort will be made to contact me in order to receive my specific authorization before any major medical treatment or hospitalization is undertaken.

Date:____________ Signature:________________________

WCS PLAYER CONTRACT/PARENTAL CONSENT FORM

Please Print:

Student-athlete Name:

____
First   Last

Please initial each statement below:

_______ I have read the Warren Consolidated Schools Athletic Handbook Guidelines for
Initials   Parents/Guardians/Athletes and the Player's Contract, and I understand its contents.

_______ I pledge to NOT violate the rules of the Student Code of Conduct and the Player's
Initials   Contract.

_______ I understand and will follow the district's transportation policy as listed in this
Initials   handbook.

_______ A copy of this contract must be on file with the athletic director. I understand the
Initials   consequences for violating the terms of this contract.

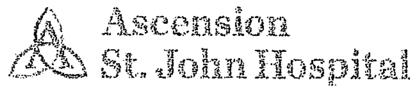
______________________ Athlete's Signature

______________________ Parent/Guardian Signature

______________________ Date

______________________ Date

Graduation Year: ____________



Dear Sterling Heights High School Parents,

Welcome back to a new season of Stallion Athletics! My name is Samantha Viola (Sam), and I am the Athletic Trainer for Sterling Heights High School. I wanted to take this opportunity to introduce myself and introduce you to some procedures that I would like you to be aware of as a parent of a student-athlete here at Sterling Heights. It is important for me to inform you of the policies in order for us to be on the same page when it comes to the treatment and well-being of your student-athlete, and to help me get your child back on the playing field as soon as possible.

First and foremost. What is an Athletic Trainer, you ask?
I'm so glad you did! Being an Athletic Trainer (AT or ATC), there is a tendency for people to confuse me with a personal trainer and other professions alike. Let me help clarify how I can help your student-athlete from a medical standpoint. Athletic Trainers are certified by the BOC and licensed in their state. I have my Bachelors of Science in Athletic Training from Michigan State University and my Masters of Science in Sports Medicine from Georgia State University, and have been practicing for 7 years in a variety of settings such as collegiate, clinical, and high school. More specifically, ATC's are highly qualified, multi-skilled health care professionals who render service or treatment for orthopedic injuries, under the direction of or in collaboration with a physician, in accordance with their education, training and the state's statutes, rules and regulations.

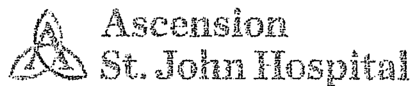
To name a few, here are some services we provide:

- Injury and illness prevention
- Wellness promotion and education
- Emergent care such as CPR, splinting, and much more!
- Examination and clinical diagnosis of orthopedic injuries and other pathologies such as skin conditions, heat illness conditions, etc.
- Therapeutic intervention and rehabilitation of orthopedic injuries and medical conditions

If your student-athlete gets injured at practice, please have them communicate with their coach immediately to be evaluated.

Contact Information
Please do not hesitate to contact me if you have questions or concerns. Your child's health is my first priority! Phone or email is the best way to get in touch with me. If you cannot reach me, chances are I am at Ascension St. John Main Hospital, as I assist with stroke patients in the neuro outpatient rehabilitation center. If your student-athlete would like to get in contact with me directly they can do so on the remind app.
Remind: **@shsprtsmd**
Office: **586-698-4973**
Email: **samantha.viola@ascension.org**
Address: **Attn: Samantha Viola 12901 15 Mile Rd, Sterling Heights, MI 48312**

Athletic Training Room Hours
During the school year I will arrive to the athletic training room by **2:00 pm Monday-Friday**. Please encourage your student-athletes to come immediately to the athletic training room if they need my assistance. If there are no games, I will leave between **5:30 and 6:00 pm**. If there are home games scheduled, I will be on school property until the conclusion of the games. My schedule will be posted on the band app for coaches to access. If your student-athlete is in need of assistance please have them either contact me directly, or ask their coach to contact me.



Reporting Injuries

It is very important that all injuries are reported to me as soon as possible. I have available resources that allow me to provide our athletes the best and quickest care available. This includes access to local orthopedic doctors such as our team doctor, Dr. Nathan Marshall at Stonebridge Orthopedics, as well as local physical therapists with whom I can schedule appointments with quickly. Please feel free to utilize me in this manner for yourself in addition to your student athlete. If an injury occurs at an away game, please do not hesitate to contact me to inform me or to ask for my assistance.

It is expected that your student-athlete communicate with me directly when they need my assistance. I cannot help with injuries that go unreported! Our goal is to nip an injury in the bud before it becomes a larger problem. Think it's no big deal? Report it anyway! I'm here to help :)

Concussion Policy

According to Michigan State Law, and MHSAA regulations, "Any athlete who exhibits signs, symptoms, or behaviors consistent with a concussion (such as loss of consciousness, headache, dizziness, confusion, or balance problems) shall be immediately removed from the contest and shall not return to play until cleared by an appropriate health care professional." (this includes practice) In order for the athlete to return to sport, the Certified Athletic Trainer must receive a written clearance from an MD/DO/NP/or PA AND the athlete must complete a stepwise gradual return to play progression. I strongly encourage all parents to visit the following website for detailed information regarding concussions and return to play guidelines:

https://www.mhsaa.com/Schools/Health-Safety-Resources/Heads

Returning an Athlete to Play

It is a school and MHSAA policy that any time an athlete seeks care from a physician, no matter the reason, that athlete may not return to play until we receive a written note from the physician releasing the athlete for full participation with no restrictions. There is no exception to this rule. All notes must be given to the Athletic Trainer or Athletic Director prior to participation.

Thank you so much for following along, and again, please don't hesitate to contact me with any problems or concerns. I look forward to serving you and your student-athletes to the best of my ability as your school's licensed and certified Athletic Trainer!

Thank you,

Samantha Viola, MS, AT, ATC
Certified/Licensed Athletic Trainer
Sterling Heights High School
Ascension St. John Hospital
samantha.viola@ascension.org