Stallion Athletics
Pre-Season Eligibility Check List
Athletic Director: Jason Kluzak
(586) 698-4622 jkluzak@wcskids.net
Twitter: @SHHS_BlacknGold

To participate in athletics at Sterling Heights High School the information and check list provided below must be completed and verified by Mr. Kluzak before the first practice. Your stamped Medical Cards will serve as your permission slip to participate for your coach.

Name:_____ Grade:____
Sport:_____ D.O.B.:_____

Check List:

*Completed Physical After April 15 (**No Blank Areas**) ____*
***Two** Completed WCS Medicals Treatment Cards ____*
*Completed WCS Handbook/Contract (**Booklet**) ____*
*Passing **4** out 6 Classes from Past Semester ____*

Athletes Signature _____ Date: _____
Mr. Kluzak's Signature:_____ Date: _____

MICHIGAN HIGH SCHOOL ATHLETIC ASSOCIATION, INC.

MEDICAL HISTORY

- To be completed by parent or guardian or 18-year-old.
- Must be signed below by parent or guardian or 18-year-old.

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

LAST	FIRST	MI	SEX	GRADE	DATE OF BIRTH	AGE
STUDENT'S NAME:					--- ---	

NUMBER AND STREET	CITY	ZIP
STUDENT'S ADDRESS:		

NAME OF FATHER OR GUARDIAN	WORK PHONE	NAME OF MOTHER OR GUARDIAN	WORK PHONE

FAMILY DOCTOR	OFFICE PHONE	STUDENT'S HOME PHONE

MEDICAL HISTORY

GENERAL QUESTIONS	YES	NO
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 by Circling: Asthma Anemia Diabetes Infections Other: _____		
Have you ever spent the night in the hospital?		
Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**YES**	**NO**
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?		
Do you get lightheaded or feel more short of breath than expected during exercise?		
Do you get more tired or short of breath more quickly than your friends during exercise?		
Has a doctor ever ordered a test for your heart? For example: ECG/EKG, echocardiogram		
Have you ever had an unexplained seizure or do you have a history of seizure disorder?		
Does your heart ever race or skip beats (irregular beat) during exercise?		
Has a doctor ever told you that you have high blood pressure?		
Has a doctor ever told you that you have high cholesterol?		
Has a doctor ever told you that you have Kawasaki disease?		
Has a doctor ever told you that you have other heart problems?		
Has a doctor ever told you that you have a heart infection?		
Has a doctor ever told you that you have a heart murmur?		
YOUR FAMILY'S HEART HEALTH QUESTIONS	**YES**	**NO**
Does anyone in your family have a heart problem, Pacemaker, or implanted defibrillator?		
Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, Brugada syndrome?		
Anyone in your family had unexplained fainting?		
Anyone in your family had unexplained seizures?		
Anyone in your family had unexplained near drowning?		

YOUR FAMILY'S HEART HEALTH QUESTIONS	YES	NO
Does anyone in your family have arrhythmogenic right ventricular cardiomyopathy, long QT syndrome?		
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 catecholamincrgic polymorphic ventricular tachycardia, short QT syndrome?		
BONE AND JOINT QUESTIONS	**YES**	**NO**
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 or dislocated joints?		
Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace or cast or crutches?		
Have you ever been told that you have neck instability or atlantoaxial instability (Down syndrome or dwarfism)?		
Have you ever had an x-ray for neck instability or atlantoaxial instability (Down syndrome or dwarfism)?		
Do you regularly use a brace, orthotics, or other assistive device?		
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 a stress fracture?		
Have you a bone, muscle, or joint injury bothering you?		
IMMUNIZATION HISTORY	**YES**	**NO**
Are you missing any recommended vaccines (Tdap, Flu, MCV4, HPV, Varicella, MMR)		
MEDICAL QUESTIONS	**YES**	**NO**
Have you ever become ill while exercising in the heat?		
Do you cough, wheeze, or have difficulty breathing during or after exercise?		
Do you have headaches or get frequent muscle cramps When exercising?		
Do you have pain, a painful bulge or hernia in the groin?		
Is there any one in your family who has asthma?		
Have you ever used an inhaler or taken asthma medicine?		

MEDICAL QUESTIONS	YES	NO
Do you have any concerns that you would like to discuss with a doctor?		
Were you born without or are you missing an organ? Identify by circling: A kidney An eye Your spleen A testicle (males) Any other organ? _____		
Have you ever had an eating disorder?		
Do you worry about your weight?		
Have you ever had a head injury or concussion?		
Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
Have you ever been unable to move your arms or legs after being hit or falling?		
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?		
Do you wear protective eyewear, such as goggles, or a face shield?		
Do you or someone in your family have sickle cell trait or disease?		
Have you had any problems with your eyes or vision or had any eye injuries?		
Do you wear glasses or contact lenses?		
Have you ever had herpes or MRSA skin infection?		
Have you had infectious mononucleosis (mono) within the last month?		
Do you have any rashes, pressure sores, or other skin problems?		
Do You Have Any Allergies?		
FEMALES ONLY	**YES**	**NO**
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 twelve (12) months?		

INSURANCE STATEMENT AND CERTIFICATION

Our Son/Daughter will comply with the specific insurance regulations of the school district and the Medical History questions are as complete and correct as possible.

Family Insurance Co: _____ Insurance ID #: _____

Signatures of Student: _____ & Parent/Guardian or 18 Year Old: _____

---------- < DETACH HERE IF NEEDED TO ACCOMPANY STUDENT ATHLETE > ----------

EMERGENCY INFORMATION – To Be Completed by Parent or Guardian or 18 Year Old

Student's Name: _____ Grade: _____

IN EMERGENCY CONTACT 1) _____ Phone #: _____ Cell #: _____

or 2) _____ Phone #: _____ Cell #: _____

Family Doctor: _____ Phone: _____

Allergies: _____

Drug Reactions: _____

Current Medications: _____

MICHIGAN HIGH SCHOOL ATHLETIC ASSOCIATION, INC.
PHYSICAL EXAM & CLEARANCE & CONSENT FORMS

- To be completed by parent or guardian or 18-year-old.
- Must be signed in ***two*** places on this page by parent or guardian or 18-year-old.

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

PLEASE PRINT

	Last	First	Middle
STUDENT'S COMPLETE LEGAL NAME:			

	Month	Day	Year		City	State
STUDENT'S DATE OF BIRTH:				PLACE OF BIRTH:		

CIRCLE GRADE: 6 7 8 9 10 11 12 SCHOOL:

PHYSICAL EXAMINATION & MEDICAL CLEARANCE

To be completed by the examining MD, DO, PA or NP & Returned Directly to the patient. Categories may be added or deleted. Check Appropriate Column

EXAMINATION: (Circle Correct Response As Necessary) Height: Weight: Male/Female BP: / Pulse: Vision: R 20/ L 20/ Corrected: Yes No

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: 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 FINDINGS
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 - TENNIS - TRACK & FIELD - VOLLEYBALL - WRESTLING

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

SIGNATURE OF EXAMINER: _____ CIRCLE ONE MD DO PA NP

PRINTED NAME OF EXAMINER: _____ DATE: _____

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.

Signature of STUDENT: _____ **Date:** _____

Signature of PARENT: or GUARDIAN or 18 YEAR-OLD _____ **Date:** _____

---------- **< DETACH HERE IF NEEDED TO ACCOMPANY STUDENT ATHLETE >** ----------

MEDICAL TREATMENT CONSENT – To Be 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.

_____ _____

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.

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.

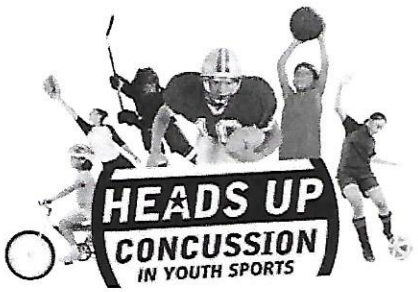
_____ A copy of this contract must be on file with the athletic director. I understand the
Initials consequences for violating the terms of this contract.

_____ _____
Athlete's Signature Parent/Guardian Signature

_____ _____
Date Date

Graduation Year: _____

ST JOHN PROVIDENCE HEALTH SYSTEM



Parent/Athlete Concussion Information Sheet

A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by bump, blow, or jolt to the head or body that causes the head and brain to move rapidly back and forth. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

Did You Know?

- Most concussions occur *without* loss of consciousness.
- Athletes who have, at any point in their lives, had a concussion have an increased risk for another concussion.
- Young children and teens are more likely to get a concussion and take longer to recover than adults.

WHAT ARE THE SIGNS AND SYMPTOMS OF CONCUSSION?

Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury.

If an athlete reports ***one or more*** symptoms of concussion listed below after a bump, blow, or jolt to the head or body, s/he should be kept out of play the day of the injury and until a health care professional, experienced in evaluating for concussion, says s/he is symptom-free and it's OK to return to play.

SIGNS OBSERVED BY COACHING STAFF	SYMPTOMS REPORTED BY ATHLETES
Appears dazed or stunned	Headache or "pressure" in head
Is confused about assignment or position	Nausea or vomiting
Forgets an instruction	Balance problems or dizziness
Is unsure of game, score, or opponent	Double or blurry vision
Moves clumsily	Sensitivity to light
Answers questions slowly	Sensitivity to noise
Loses consciousness *(even briefly)*	Feeling sluggish, hazy, foggy, or groggy
Shows mood, behavior, or personality changes	Concentration or memory problems
Can't recall events *prior* to hit or fall	Confusion
Can't recall events *after* hit or fall	Just not "feeling right" or "feeling down"

CONCUSSION DANGER SIGNS

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. An athlete should receive immediate medical attention if after a bump, blow, or jolt to the head or body s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that not only does not diminish, but gets worse
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people or places
- Becomes increasingly confused, restless, or agitated
- Has unusual behavior
- Loses consciousness *(even a brief loss of consciousness should be taken seriously)*

WHY SHOULD AN ATHLETE REPORT THEIR SYMPTOMS?

If an athlete has a concussion, his/her brain needs time to heal. While an athlete's brain is still healing, s/he is much more likely to have another concussion. Repeat concussions can increase the time it takes to recover. In rare cases, repeat concussions in young athletes can result in brain swelling or permanent damage to their brain. *They can even be fatal.*

Remember

Concussions affect people differently. While most athletes with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer.

WHAT SHOULD YOU DO IF YOU THINK YOUR ATHLETE HAS A CONCUSSION?

If you suspect that an athlete has a concussion, remove the athlete from play and seek medical attention. Do not try to judge the severity of the injury yourself. Keep the athlete out of play the day of the injury and until a health care professional, experienced in evaluating for concussion, says s/he is symptom-free and it's OK to return to play.

Rest is key to helping an athlete recover from a concussion. Exercising or activities that involve a lot of concentration, such as studying, working on the computer, or playing video games, may cause concussion symptoms to reappear or get worse. After a concussion, returning to sports and school is a gradual process that should be carefully managed and monitored by a health care professional.

It's better to miss one game than the whole season. For more information on concussions, visit: www.cdc.gov/Concussion

Student-Athlete Name Printed	Student-Athlete Signature	Date
Parent or Legal Guardian Printed	Parent or Legal Guardian Signature	Date