



**STALLION ATHLETICS  
 ATHLETIC ELIGIBILITY CHECK LIST  
 ATHLETIC DIRECTOR: STEVEN SCHIESEL  
 (586) 698-4622 [sschiesel@wcskids.net](mailto: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:** \_\_\_\_\_

**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  
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  
Contract.

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

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

Athlete's Signature \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Date \_\_\_\_\_

Graduation Year: \_\_\_\_\_







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: \_\_\_\_\_



**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: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections <input type="checkbox"/> 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: <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur <input type="checkbox"/> Heart infection <input type="checkbox"/> High cholesterol <input type="checkbox"/> Kawasaki disease <input type="checkbox"/> 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	MUSCULOSKELETAL	NORMAL	ABNORMAL
Appearance: Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)			Neck		
Eyes/Ears/Nose/Throat: Pupils Equal Hearing			Back		
Lymph nodes			Shoulder/Arm		
Heart: Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (PMI)			Elbow/Forearm		
Pulses: Simultaneous femoral and radial pulses			Wrist/Hand/Fingers		
Lungs			Hip/Thigh		
Abdomen			Knee		
Genitourinary (males only)			Leg/Ankle		
Skin: HSV: Lesions suggestive of MRSA, tinea corporis			Foot/Toes		
Neurologic			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: \_\_\_\_\_