



# MSHSAA PRE-PARTICIPATION PHYSICAL PACKET

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## Timberland High School

*Please visit our Family Athletic Registration website*

*<https://timberland-ar.rschoolday.com/>.*

### **ALL STUDENTS ARE REQUIRED TO REGISTER ON LINE FOR ATHLETICS.**

The Physical Exam & MSHSAA Pre-Participation Documentation forms are completed by your Doctor's office at the time of your physical exam (attached).

**ALL PARTICIPATION PACKETS ARE ONLY ACCEPTED IN PERSON AT THE ACTIVITIES OFFICE. DO NOT LEAVE WITH THE MAIN OFFICE. WE DO NOT ACCEPT FAXED COPIES OF YOUR PHYSICAL FROM YOUR DOCTOR'S OFFICE.**

*Thoroughly complete ALL sections of this packet. If any area is incomplete, the packet will be returned to you for completion.*

*The following must be completed BY THE SEASON'S FINAL CLEARANCE CUTOFF DATE: (Visit our website & click on that season's page (Fall, Winter, Spring for the final clearance cutoff date)*

***All physicals are valid for two (2) years from the date of issue per MSHSAA guidelines.***

1. Required to complete the online Family Athletic Registration & upload a PDF file of your Physical Exam & Medical History forms to your profile <https://timberland-ar.rschoolday.com/>.
2. If you haven't uploaded your Physical Exam & Medical History forms, turn in completed packet to the Activities office before the final clearance cutoff date. Paperwork turned in early is appreciated!
3. Take ImPACT test with Timberland Athletic Trainer (concussion test) (required every two (2) years)
4. Obtain Final Clearance from Activities office by the cutoff date. This is required to participate in tryouts/practices for each season. Final clearances will NOT be issued after the cutoff date for each season.
5. Give Final Clearance to coach the first day of tryouts/practices.

**THESE FORMS CAN ALSO BE FOUND ON THE TIMBERLAND ATHLETICS/ACTIVITIES WEBPAGE. HOVER OVER ACTIVITIES, SCROLL DOWN & CLICK ON THE LINK "MSHSAA PRE-PARTICIPATION PHYSICAL PACKET".**



# Wentzville R-IV School District Activities 3 in 1 Form

STUDENT NAME \_\_\_\_\_ (Please print) DATE OF BIRTH \_\_\_\_\_ GRADE \_\_\_\_\_

PARENT/GUARDIAN \_\_\_\_\_ (please print) EMERGENCY CONTACT PHONE # \_\_\_\_\_

### **Coaches, Athletes and Parents MEETING**

We have attended the educational C.A.P. meeting and have received the Eligibility, Activities Handbook and Concussions Information.

STUDENT SIGNATURE \_\_\_\_\_ PARENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

*If you were unable to attend the C.A.P. meeting please follow the directions below for the On-Line C.A.P. Meeting information.*

Go to: [www.wentzville.k12.mo.us](http://www.wentzville.k12.mo.us)

Go to SCHOOL INFORMATION, Scroll down to your high school, Click on Athletics/Activities (on the left of the page)

At the bottom of the page click on C.A.P. Meeting PowerPoint, View all power point presentations and initial below:

My child and I were not able to attend the C.A.P. meeting but we have viewed the following materials on the Wentzville website:

- We have viewed the power point presentation titled "C.A.P. Meeting";
- We have viewed the power point presentation link titled "MSHSAA Concussions";
- We have viewed the power point presentation link titled "MSHSAA Eligibility Brochure".

STUDENT SIGNATURE \_\_\_\_\_ PARENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

### **ATHLETIC/ACTIVITIES HANDBOOK**

We have read the rules concerning eligibility and conduct for students and athletes. We understand the rules and realize that the athlete is subject to disciplinary measures should he/she violate them.

We have read the Athletic/Activities Handbook and agree to abide by the sportsmanship, citizenship/conduct, tobacco, alcohol, and drug expectations. We understand that this agreement in no way limits the athlete's right to terminate or to be terminated from student activity participation.

STUDENT SIGNATURE \_\_\_\_\_ PARENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

### **ImPACT Testing**

#### Consent for Cognitive Testing and Release of Information

I give my permission for my child to have baseline and, if necessary, a post-concussion ImPACT (Immediate Post-Concussion Assessment and Cognitive Testing) administered at my child's high school. I understand that my child may need to be tested more than once, depending on the results of the test, as compared to my child's baseline test, which is on file at my attending high school. I understand there is no charge for the testing.

My child's high school may release the ImPACT results to my child's primary care physician, neurologist, school athletic trainer, school nurse, Dr. Brandon Larkin (District ImPACT coordinator), or other treating physician.

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

STUDENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PARENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

# PRE-PARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM – VALID FOR 2 YEARS

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                         |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|
| Name:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | Date of Birth:                                                                                                                                                                                                                                                                                                                                                                      |                                                                                         |
| <b>Physician Reminders:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                         |
| 1. Consider additional questions on more-sensitive issues. <ul style="list-style-type: none"> <li>• Do you feel stressed out or under a lot of pressure?</li> <li>• Do you ever feel sad, hopeless, depressed or anxious?</li> <li>• Do you feel safe at your home or residence?</li> <li>• Have you ever tried cigarettes, chewing tobacco, snuff or dip?</li> <li>• During the past 30 days, did you use chewing tobacco, snuff or dip?</li> </ul>                                                                                                                                                          |  | <ul style="list-style-type: none"> <li>• Do you drink alcohol or use any other drugs?</li> <li>• Have you ever taken anabolic steroids or used any other performance-enhancing supplement?</li> <li>• Have you ever taken any supplements to help you gain or lose weight or improve your performance?</li> <li>• Do you wear a seat belt, use a helmet and use condoms?</li> </ul> |                                                                                         |
| 2. Consider reviewing questions on cardiovascular symptoms (Questions 4-13 of History Form).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                         |
| <b>EXAMINATION</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                         |
| Height:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | Weight:                                                                                                                                                                                                                                                                                                                                                                             |                                                                                         |
| BP: / ( / )                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | Pulse:                                                                                                                                                                                                                                                                                                                                                                              | Vision: R 20/ L 20/ Corrected: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <b>MEDICAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | <b>NORMAL</b>                                                                                                                                                                                                                                                                                                                                                                       | <b>ABNORMAL FINDINGS</b>                                                                |
| Appearance <ul style="list-style-type: none"> <li>• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse (MVP) and aortic insufficiency)</li> </ul>                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                         |
| Eyes, ears, nose and throat <ul style="list-style-type: none"> <li>• Pupils equal</li> <li>• Hearing</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                         |
| Lymph Nodes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                         |
| Heart* <ul style="list-style-type: none"> <li>• Murmurs (auscultation standing, auscultation supine and +/- Valsalva maneuver)</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                         |
| Lungs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                         |
| Abdomen                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                         |
| Skin <ul style="list-style-type: none"> <li>• Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA) or tinea corporis</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                         |
| Neurological                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                         |
| <b>MUSCULOSKELETAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | <b>NORMAL</b>                                                                                                                                                                                                                                                                                                                                                                       | <b>ABNORMAL FINDINGS</b>                                                                |
| Neck                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                         |
| Back                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                         |
| Shoulder and arm                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                         |
| Elbow and forearm                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                         |
| Wrist, hand and fingers                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                         |
| Hip and thigh                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                         |
| Knee                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                         |
| Leg and ankle                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                         |
| Foot and toes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                         |
| Functional <ul style="list-style-type: none"> <li>• Double-leg squat test, single-leg squat test and box drop or step drop test</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                         |
| * Consider electrocardiography (ECG), echocardiogram, referral to cardiology for abnormal cardiac history or examination findings, or a combination of those.                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                         |
| <input type="checkbox"/> Cleared for all sports without restriction for two (2) years unless otherwise noted below under "Recommendations."                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                         |
| <input type="checkbox"/> Cleared for all sports without restriction with recommendations for further evaluation or treatment for:                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                         |
| <input type="checkbox"/> Not Cleared <ul style="list-style-type: none"> <li><input type="checkbox"/> Pending further evaluation</li> <li><input type="checkbox"/> For any sports</li> <li><input type="checkbox"/> For certain sports (please list):</li> </ul> Reason:                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                         |
| Recommendations:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                         |
| I have examined the above-named student and completed the pre-participation 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, the 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 healthcare professional (type/print):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                     | Date of Issue:                                                                          |
| Address:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                                                                                     | Phone:                                                                                  |
| Signature of healthcare professional (MD/DO/ARNP/PA/Chiropractor):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                         |

**This physical is valid for a 2-year period unless otherwise noted by the physician in the "Recommendations" field listed above.**

## MSHSAA PRE-PARTICIPATION DOCUMENTATION – ANNUAL REQUIREMENTS

| MEDICAL HISTORY                                                                                                                                                                                                                                                                       |                                                   |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|
| <p><b>Note: Complete and sign this form (with your parents if younger than 18) before your appointment. The physician should keep a copy of this form in the chart for their records.</b><br/> <b>Note: An injury or medical condition results in a separate medical release.</b></p> |                                                   |
| Name:                                                                                                                                                                                                                                                                                 | Date of Birth:                                    |
| Date of examination:                                                                                                                                                                                                                                                                  |                                                   |
| Sex assigned at birth (F, M or intersex):                                                                                                                                                                                                                                             | How do you identify your gender? (F, M or other): |
| List past and current medical conditions:                                                                                                                                                                                                                                             |                                                   |
| Have you ever had surgery? If yes, list all past surgical procedures:                                                                                                                                                                                                                 |                                                   |
| Medicines and supplements: List all current prescriptions, over-the-counter medicines and supplements (herbal and nutritional):                                                                                                                                                       |                                                   |
| Do you have any allergies? If yes, please list all of your allergies (i.e., medicines, pollens, food, stinging insects):                                                                                                                                                              |                                                   |

| PATIENT HEALTH QUESTIONNAIRE VERSION 4 (PHQ-4)                                                                                                         |                   |                     |                           |                         |
|--------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|---------------------|---------------------------|-------------------------|
| Over the last 2 weeks, how often have you been bothered by any of the following problems (circle response).                                            |                   |                     |                           |                         |
|                                                                                                                                                        | <b>Not at All</b> | <b>Several Days</b> | <b>Over Half the Days</b> | <b>Nearly Every Day</b> |
| Feeling nervous, anxious or on edge:                                                                                                                   | 0                 | 1                   | 2                         | 3                       |
| Not being able to stop or control worrying:                                                                                                            | 0                 | 1                   | 2                         | 3                       |
| Little interest or pleasure in doing things:                                                                                                           | 0                 | 1                   | 2                         | 3                       |
| Feeling down, depressed or hopeless:                                                                                                                   | 0                 | 1                   | 2                         | 3                       |
| <p><b>A sum of <math>\geq 3</math> is considered positive on either subscale (questions 1 and 2, or questions 3 and 4) for screening purposes.</b></p> |                   |                     |                           |                         |

Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.

| GENERAL QUESTIONS                                                                                                                                                                                                                                                                                                    | Yes | No |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| 1. Do you have any concerns that you would like to discuss with your provider?                                                                                                                                                                                                                                       |     |    |
| 2. Has a provider ever denied or restricted your participation in sports for any reason?                                                                                                                                                                                                                             |     |    |
| 3. Do you have any ongoing medical issues or recent illness?                                                                                                                                                                                                                                                         |     |    |
| HEART HEALTH QUESTIONS ABOUT YOU                                                                                                                                                                                                                                                                                     | Yes | No |
| 4. Have you ever passed out or nearly passed out during or after exercise?                                                                                                                                                                                                                                           |     |    |
| 5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?                                                                                                                                                                                                                         |     |    |
| 6. Does your heart ever race or skip beats (irregular beats) during exercise?                                                                                                                                                                                                                                        |     |    |
| 7. Has a doctor ever told you that you have any heart problems?                                                                                                                                                                                                                                                      |     |    |
| 8. Has a doctor ever ordered a test for your heart? (For example, electrocardiography (ECG) or echocardiography?)                                                                                                                                                                                                    |     |    |
| 9. Do you get light-headed or feel shorter of breath than your friends during exercise?                                                                                                                                                                                                                              |     |    |
| 10. Have you ever had a seizure?                                                                                                                                                                                                                                                                                     |     |    |
| HEART HEALTH QUESTIONS ABOUT YOUR FAMILY                                                                                                                                                                                                                                                                             | Yes | No |
| 11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 (including drowning or unexplained car crash)?                                                                                                                                           |     |    |
| 12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome or catecholaminergic polymorphic ventricular tachycardia (CPVT)? |     |    |
| 13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?                                                                                                                                                                                                                           |     |    |
| BONE AND JOINT QUESTIONS                                                                                                                                                                                                                                                                                             | Yes | No |
| 14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint or tendon that caused you to miss a practice or game?                                                                                                                                                                        |     |    |
| 15. Do you have a bone, muscle, ligament or joint injury that bothers you?                                                                                                                                                                                                                                           |     |    |

| MEDICAL QUESTIONS                                                                                                                                     | Yes | No |
|-------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| 16. Do you cough, wheeze, or have difficulty breathing during or after exercise?                                                                      |     |    |
| 17. Are you missing a kidney, an eye, a testicle (males), your spleen or any other organ?                                                             |     |    |
| 18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?                                                                |     |    |
| 19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)?  |     |    |
| 20. Have you had a concussion or head injury that caused confusion, a prolonged headache or memory problems?                                          |     |    |
| 21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling? |     |    |
| 22. Have you ever become ill while exercising in the heat?                                                                                            |     |    |
| 23. Do you, or does someone in your family, have sickle cell trait or disease?                                                                        |     |    |
| 24. Have you ever had, or do you have, any problems with your eyes or vision?                                                                         |     |    |
| 25. Do you worry about your weight?                                                                                                                   |     |    |
| 26. Are you trying to, or has anyone recommended, that you gain or lose weight?                                                                       |     |    |
| 27. Are you on a special diet or do you avoid certain types of foods or food groups?                                                                  |     |    |
| 28. Have you ever had an eating disorder?                                                                                                             |     |    |
| FEMALES ONLY                                                                                                                                          | Yes | No |
| 29. Have you ever had a menstrual period?                                                                                                             |     |    |
| 30. How old were you when you had your first menstrual period?                                                                                        |     |    |
| 31. When was your most recent menstrual period?                                                                                                       |     |    |
| 32. How many periods have you had in the past 12 months?                                                                                              |     |    |

IF "YES," EXPLAIN ANSWERS HERE. PLEASE INDICATE # ABOVE NEXT TO EXPLANATION.

|  |
|--|
|  |
|--|

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

|                                     |
|-------------------------------------|
| Signature of Athlete:               |
| Signature of Parent(s) or Guardian: |
| Date:                               |

**PARENT PERMISSION (Authorization for Treatment, Release of Medical Information, and Insurance Information)**

**Informed Consent:** By its nature, participation in interscholastic athletics includes risk of serious bodily injury and transmission of infectious disease such as HIV and Hepatitis B. Although serious injuries are not common and the risk of HIV transmission is almost nonexistent in supervised school athletic programs, it is impossible to eliminate all risk. Participants must obey all safety rules, report all physical and hygiene problems to their coaches, follow a proper conditioning program, and inspect their own equipment daily. **PARENTS, GUARDIANS, OR STUDENTS WHO MAY NOT WISH TO ACCEPT RISK DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS FORM. STUDENTS MAY NOT PARTICIPATE IN MSHSAA-SPONSORED SPORT WITHOUT THE STUDENT'S AND PARENT'S/GUARDIAN/S SIGNATURE.**

I understand that in the case of injury or illness requiring transportation to a health care facility, a reasonable attempt will be made to contact the parent or guardian in the case of the student-athlete being a minor, but that, if necessary, the student-athlete will be transported via ambulance to the nearest hospital.

We hereby give our consent for the above student to represent his/her school in interscholastic athletics. We also give our consent for him/her to accompany the team on trips and will not hold the school responsible in case of accident or injury whether it be en route to or from another school or during practice or an interscholastic contest; and we hereby agree to hold the school district of which this school is a part and the MSHSAA, their employees, agents, representatives, coaches, and volunteers harmless from any and all liability, actions, causes of action, debts, claims, or demands of every kind and nature whatsoever which may arise by or in connection with participation by my child/ward in any activities related to the interscholastic program of his/her school.

In the event of an emergency or when the Parent(s) or Guardian is unable to directly supervise health care services needed by the student for injuries or illnesses sustained at any athletic practice, conditioning exercise or contest, I also give my consent to the rendering of necessary health care services for the student by a qualified provider (QP) covering the athletic practice, conditioning exercise or contest, including an athletic trainer, physician, physician assistant, nurse practitioner or other medically-trained professional licensed by the State of Missouri (or the state in which the student injury or illness occurs) and who is acting in accordance with the scope of practice under their designated state license and any other requirement imposed by state law. In emergency situations, the QP may also be a certified paramedic or emergency medical technician for the purpose of providing emergency health care and transport. Health care services are defined as services including, but not limited to, evaluation, diagnosis, first aid, emergency care, stabilization, treatment and referral. I further authorize the QP who provides such health care services to disclose such information about the student's injury or illness, diagnosis, care and treatment in the professional judgment of the QP to the student's athletic director, coaches, school nurse and any classroom teacher required to provide academic accommodation to assure the student's recovery and safe return to activity. If the Parent(s) or Guardian believes that the student is in need of further evaluation, treatment, rehabilitation or health care services for the injury or illness, the student may be treated by the physician or provider of his or her choice.

To enable the MSHSAA to determine whether the herein named student is eligible to participate in interscholastic athletics in the MSHSAA member school, I consent to the release of any and all portions of school record files to MSHSAA, beginning with seventh grade, of the herein named student, specifically including, without limiting the generality of the foregoing, birth and age records, name and residence address of parent(s) or guardian(s), residence address of the student, academic work completed, grades received, and attendance data.

We confirm that this application for the above student to represent his/her school in interscholastic athletics is made with the understanding that we have studied and understand the eligibility standards that our son/daughter must meet to represent his/her school and that he/she has not violated any of them. We also understand that if our son/daughter does not meet the citizenship standards set by the school or if he/she is ejected from an interscholastic contest because of an unsportsmanlike act, it could result in him/her not being allowed to participate in the next contest or suspension from the team either temporarily or permanently.

I consent to the MSHSAA's use of the herein named student's name, likeness, and athletic-related information in reports of contests, promotional literature of the Association and other materials and releases related to interscholastic athletics.

We further state that we have completed that part of this certificate which requires us to list all previous injuries or additional conditions that are known to us which may affect this athlete's performance or treatment and we certify that it is correct and complete.

The MSHSAA By-Laws provide that a student shall not be permitted to practice or compete for a school until it has verification that he/she/they has basic health/accident insurance coverage, which includes athletics. Our son/daughter is covered by basic health/accident insurance for the current school year as indicated below:

|                                                                                             |                                                                        |
|---------------------------------------------------------------------------------------------|------------------------------------------------------------------------|
| <b>Name of Insurance Company:</b>                                                           | <b>Policy Number:</b>                                                  |
| <b>Signature of Parent(s) or Guardian:</b>                                                  | <b>Date:</b>                                                           |
| <b>Has this student incurred a medical condition since their last physical examination?</b> | <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> |

**STUDENT AGREEMENT (Regarding Conditions for Participation)**

This application to represent my school in interscholastic athletics is entirely voluntary on my part and is made with the understanding that I have studied and understand the eligibility standards that I must meet to represent my school and that I have not violated any of them.

I have read, understand, and acknowledge receipt of the MSHSAA brochure entitled "How to Maintain and Protect Your High School Eligibility," which contains a summary of the eligibility rules of the MSHSAA. (I understand that a copy of the *MSHSAA Handbook* is on file with the principal and athletic administrator and that I may review it in its entirety, if I so choose. All MSHSAA by-laws and regulations from the *Handbook* are also posted on the MSHSAA website at [www.mshsaa.org](http://www.mshsaa.org)).

I understand that a MSHSAA member school must adhere to all rules and regulations that pertain to school-sponsored, interscholastic athletics programs, and I acknowledge that local rules may be more stringent than MSHSAA rules.

I also understand that if I do not meet the citizenship standards set by the school or if I am ejected from an interscholastic contest because of an unsportsmanlike act, it could result in me not being allowed to participate in the next contest or suspension from the team either temporarily or permanently.

I understand that if I drop a class, take course work through Post -Secondary Enrollment Option, Credit Flexibility, or other educational options, this action could affect compliance with MSHSAA academic standards and my eligibility.

I understand that participation in interscholastic athletics is a privilege and not a right. As a student athlete, I understand and accept the following responsibilities:

- I will respect the rights and beliefs of others and will treat others with courtesy and consideration.
- I will be fully responsible for my own actions and the consequences of my actions.
- I will respect the property of others.
- I will respect and obey the rules of my school and laws of my community, state, and country.
- I will show respect to those who are responsible for enforcing the rules of my school and the laws of my community, state, and country.

I have completed and/or verified that part of this certificate which requires me to list all previous injuries or additional conditions that are known to me which may affect my performance in so representing my school, and I verify that it is correct and complete.

|                                                                                       |                                                                        |
|---------------------------------------------------------------------------------------|------------------------------------------------------------------------|
| <b>Signature of Athlete:</b>                                                          | <b>Date:</b>                                                           |
| <b>Have you experienced a medical condition since your last physical examination?</b> | <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> |

**PARENT AND STUDENT SIGNATURE (Concussion Materials)**

I accept responsibility for reporting all injuries and illnesses to my school and medical staff (athletic trainer/team physician) including any signs and symptoms of a CONCUSSION. I have received and read the MSHSAA materials on Concussions, which includes information on the definition of a concussion, symptoms of a concussion, what to do if I have a concussion and how to prevent a concussion. I will inform my school and athletic trainer/team physician immediately if I experience any of these symptoms or if I witness a teammate with these symptoms.

|                                            |              |
|--------------------------------------------|--------------|
| <b>Signature of Athlete:</b>               | <b>Date:</b> |
| <b>Signature of Parent(s) or Guardian:</b> | <b>Date:</b> |

**EMERGENCY CONTACT INFORMATION**

|                              |                                |                     |
|------------------------------|--------------------------------|---------------------|
| <b>Parent(s) or Guardian</b> | <b>Address</b>                 | <b>Phone Number</b> |
| <b>Name of Contact</b>       | <b>Relationship to Athlete</b> | <b>Phone Number</b> |
| <b>Name of Contact</b>       | <b>Relationship to Athlete</b> | <b>Phone Number</b> |