

**DEUEL SCHOOL DISTRICT 19-4
2017-2018 PHYSICAL INFORMATION**

Student/Athletes Name: _____

Grade in fall: _____

Dear Parent/Guardian:

Enclosed is important information that you and your child need to read and fill out. **You must have this physical information filled out (front and back) and turned into the Athletic Director before your son/daughter can participate in any athletic activities (including practice) offered by Deuel School.**

INTERIM FORM: If your child had a physical (Form w/Doctors Signature) for the 2016-2017 school year, it is good for two more years and you need to only complete an interim pre-participation agreement. **This form does not require a Doctors Signature.**

MEDICAL INSURANCE

All students participating in interscholastic activities are required to have medical insurance. (Please check the appropriate box below)

We do have family medical insurance (or Medicaid)

We do not have family medical insurance and wish to purchase the basic family medical policy

(Athletic Director has insurance applications for school-time and full-time coverage)

**SOUTH DAKOTA HIGH SCHOOL ACTIVITIES ASSOCIATION
ANNUAL PARENT OR GUARDIAN PERMIT**

I hereby give my consent for _____ GRADE _____
Name (Please Print) 2017-18 School Year

who was born at _____ on _____
City, Town, County, State Date of Birth

to compete in SDHSAA approved athletics for the Deuel School District during the 2017-2018 school year.

I/We give our permission for our son/daughter to participate in organized high school athletics, realizing that such activity involves the potential for injury which is inherent in all sports.

Signed _____ Date _____, 20_____
Parent or Legal Guardian

THIS FORM MUST BE COMPLETED ANNUALLY AND MUST BE AVAILABLE FOR INSPECTION AT THE SCHOOL.

**SOUTH DAKOTA HIGH SCHOOL ACTIVITIES ASSOCIATION
ANNUAL PARENT AND STUDENT CONSENT FORM**

School Year: 2017-2018 Name of High School: _____

Name of Student: _____

Date of Birth: _____ Place of Birth: _____

The Parent and Student hereby:

1. Understand and agree that participation in SDHSAA sponsored activities is voluntary on the part of the student and is considered a privilege.
2. Understand and agree that (a) by this Consent Form the SDHSAA has provided notification to the parent and student of the existence of potential dangers associated with athletic participation; (b) participation in any athletic activity may involve injury of some type; (c) the severity of such injuries can range from minor cuts, bruises, sprains, and muscle strains to more serious injuries such as injuries to the body's bones, joints, ligaments, tendons, or muscles. Catastrophic injuries to the head, neck and spinal cord and concussions may also occur. On rare occasions, injuries so severe as to result in total disability, paralysis and death; and (d) even with the best coaching, use of the best protective equipment, and strict observance of rules, injuries are still a possibility.
3. Consent and agree to participation of the student in SDHSAA activities subject to all SDHSAA bylaws and rules interpretations for participation in SDHSAA sponsored activities, and the activities rules of the SDHSAA member school for which the student is participating; and
4. Consent and agree that personally identifiable directory information may be disclosed about the student as a result of his/her participation in SDHSAA sponsored activities. Such directory information may include, but is not limited to, the student's photograph, name, grade level, height, weight, and participation in officially recognized activities and sports. *If I do not wish to have any or all such information disclosed, I must notify the above mentioned high school, in writing, of our refusal to allow disclosure of any or all such information prior to the student's participation in sponsored activities.*

I acknowledge that I have read paragraphs (1) through (4) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participating in activities.

DATED this _____ day of _____, 20____

Name of Student (Print Name)

Student Signature

I am the student's parent/guardian. I acknowledge that I have read paragraphs (1) through (4) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participation in athletic activities. I hereby give my permission for _____ (student's name) to practice and compete for the above named high school in activities approved by the SDHSAA.

DATED this _____ day of _____, 20____

Parent/Guardian Signature

INSURANCE WAIVER

Dear Parent:

We wish to emphasize that the school district does not provide any type of health or accident insurance for injuries incurred by your child at school.

Since children are particularly susceptible to injuries, we encourage you to review your present health and accident insurance program to determine if your coverage is adequate. If you do not feel your insurance is adequate because of a deductible or co-insurance clause, or if you do not have insurance, we encourage you to review the student insurance program.

This year the school is making available accident insurance through Student Assurance Services, Inc. of Stillwater, MN. This plan will provide benefits for medical expenses incurred because of an accident. Information and registration materials for this insurance will be available at the pre-season fall sports meetings or at anytime during the year.

**** All questions regarding the coverage should be directed to Deuel County National Bank Insurance Agency at 874-2192, Clear Lake, SD.**

**** For your son/daughter to be eligible to participate in athletics at Deuel High School, you must either sign the waiver below or purchase student insurance this fall.**

NOTE: We encourage families to have accident coverage on their children, prior to participating in or being a spectator at any sports or co-curricular school activity.

Please sign and return the information below if you already have adequate insurance.

Thank you,

Blaine Franken

Business Manager

PARENTAL INSURANCE WAIVER

_____ We have our own insurance

_____ We want the school insurance

Student's name _____

Parent's signature _____

CO-CURRICULAR REGULATION FOR ELIGIBILITY

I understand and agree to follow the eligibility rules set by the Deuel School District as well as state and local requirements. I also agree to help the Deuel High School Athletic Dept. in the endeavor to foster a proper climate for athletic participation. I/we further agree to support and work with Deuel School District administrators and athletic department in the enforcement of the rules established by the coaches and administration if it becomes necessary.

Parent/guardian signature

Student signature

**SOUTH DAKOTA HIGH SCHOOL ACTIVITIES ASSOCIATION
ANNUAL PARENT AND STUDENT CONSENT FORM**

School Year: 2017-2018 Name of High School: _____

Name of Student: _____

Date of Birth: _____ Place of Birth: _____

The Parent and Student hereby:

1. Understand and agree that participation in SDHSAA sponsored activities is voluntary on the part of the student and is considered a privilege.
2. Understand and agree that (a) by this Consent Form the SDHSAA has provided notification to the parent and student of the existence of potential dangers associated with athletic participation; (b) participation in any athletic activity may involve injury of some type; (c) the severity of such injuries can range from minor cuts, bruises, sprains, and muscle strains to more serious injuries such as injuries to the body's bones, joints, ligaments, tendons, or muscles. Catastrophic injuries to the head, neck and spinal cord and concussions may also occur. On rare occasions, injuries so severe as to result in total disability, paralysis and death; and (d) even with the best coaching, use of the best protective equipment, and strict observance of rules, injuries are still a possibility.
3. Consent and agree to participation of the student in SDHSAA activities subject to all SDHSAA bylaws and rules interpretations for participation in SDHSAA sponsored activities, and the activities rules of the SDHSAA member school for which the student is participating; and
4. Consent and agree that personally identifiable directory information may be disclosed about the student as a result of his/her participation in SDHSAA sponsored activities. Such directory information may include, but is not limited to, the student's photograph, name, grade level, height, weight, and participation in officially recognized activities and sports. *If I do not wish to have any or all such information disclosed, I must notify the above mentioned high school, in writing, of our refusal to allow disclosure of any or all such information prior to the student's participation in sponsored activities.*

I acknowledge that I have read paragraphs one (1) through four (4) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participating in activities.

DATED this _____ day of _____, 20_____

Name of Student (Print Name) Student Signature

I am the student's parent/guardian. I acknowledge that I have read paragraphs (1) through (4) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participation in athletic activities. I hereby give my permission for _____ (student's name) to practice and compete for the above named high school in activities approved by the SDHSAA.

DATED this _____ day of _____, 20_____

Parent/Guardian (Print Name) Parent/Guardian Signature

**THIS FORM MUST BE COMPLETED ANNUALLY AND MUST BE AVAILABLE FOR
INSPECTION AT THE SCHOOL**

This is the form that the South Dakota High School Activities Association recommends to those member schools that feel it is important to get consent from parents and/or legal guardians for medical treatment when away from home on road trips for various activities. This form should be kept on file at the school and another copy should travel with each team on which the athlete competes.

CONSENT FOR MEDICAL TREATMENT

I am the **PLEASE CIRCLE ONE** Mother Father Legal Guardian of _____
_____, who participates in co-curricular activities for _____
_____ High School. I hereby consent to any medical services that may be required while said child is under the supervision of an employee of the _____ School District while on a school-sponsored activity and hereby appoint said employee to act on behalf in securing necessary medical services from any duly licensed medical provider.

Dated this _____ day of _____, 20_____

Parent(s)/Legal Guardian Signature: _____

CONSENT OF CHILD

I, _____, have read the above Consent For Medical Treatment Form signed by my (**PLEASE CIRCLE ONE**) Mother Father Legal Guardian and join with (**PLEASE CIRCLE ONE**) him her in the consent.

Dated this _____ day of _____, 20_____

Student's Signature: _____

CONSENT FOR RELEASE OF MEDICAL INFORMATION FORM (HIPAA)

Students Name _____ Date of Birth _____

1. I authorize the use or disclosure of the above named individual's health information including the Initial and Interim Pre-Participation History and Physical Exam information pertaining to a student's ability to participate in South Dakota High School Activities Association sponsored activities. Such disclosure may be made by any Health Care Provider generating or maintaining such information.
2. The information identified above may be used by or disclosed to the school nurse, athletic trainer, coaches, medical providers and other school personnel involved in the care of this student.
3. This information for which I am authorizing disclosure will be used for the purpose of determining the student's eligibility to participate in extracurricular activities, any limitations on such participation and any treatment needs of the student.
4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the school administration. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
5. This authorization will expire on July 1, 2018.
6. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
7. I understand authorizing the use or disclosure of the information identified above is voluntary. However, a student's eligibility to participate in extracurricular activities depends on such authorization. I need not sign this form to ensure healthcare treatment.

Signature of Parent

Date

This form must be completed annually and must be available for inspection at the school

CONCUSSION FACT SHEET FOR ATHLETES

What is a concussion?

A concussion is a brain injury that:

- Is caused by a bump, blow, or jolt to the head or body
- Can change the way your brain normally works
- Can occur during practices or games in any sport or recreational activity
- Can happen even if you haven't been knocked out
- Can be serious even if you've just been "dinged" or "had your bell rung"

All concussions are serious. A concussion can affect your ability to do schoolwork and other activities (such as playing video games, working on a computer, studying, driving, or exercising). Most people with a concussion get better, but it is important to give your brain time to heal.

What are the symptoms of a concussion?

You can't see a concussion, but you might notice one or more of the symptoms listed below or that you "don't feel right" soon after, a few days after, or even weeks after the injury.

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Bothered by light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty paying attention
- Memory problems
- Confusion

What should I do if I think I have a concussion?

- **Tell your coaches and your parents.** Never ignore a bump or blow to the head even if you feel fine. Also, tell your coach right away if you think you have a concussion or if one of your teammates might have a concussion.
- **Get a medical check-up.** A doctor or other health care professional can tell if you have a concussion and when it is OK to return to play.
- **Give yourself time to get better.** If you have a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have another concussion. Repeat concussions can increase the time it takes for you to recover and may cause more damage to your brain. It is important to rest and not return to play until you get the OK from your health care professional that you are symptom-free.

How can I prevent a concussion?

Every sport is different, but there are steps you can take to protect yourself.

- Use the proper sports equipment, including personal protective equipment. In order for equipment to protect you, it must be:
 - The right equipment for the game, position, or activity
 - Worn correctly and the correct size and fit
 - Used every time you play or practice
- Follow your coach's rules for safety and the rules of the sport
- Practice good sportsmanship at all times

It's better to miss one game than the whole season.

Student's Name (please print) _____ Date: _____

Student's Signature: _____ Date: _____

Parent/Guardian's Signature: _____ Date: _____

THIS FORM MUST BE SIGNED ANNUALLY AND MUST BE AVAILABLE FOR INSPECTION AT THE SCHOOL

CONCUSSION FACT SHEET FOR PARENTS

What is a concussion?

A concussion is a brain injury. Concussions are caused by a bump, blow, or jolt to the head or body. Even or what seems to be a mild bump or blow to the head can be serious.

What are the signs and symptoms?

You can't see a concussion, Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days after the injury. If your teen reports, one or more symptoms of concussion listed below, or if you notice the symptoms yourself, keep your teen out of play and seek medical attention right away.

Signs Observed By Parents or Guardians	Symptoms Reported by Athlete
<ul style="list-style-type: none"> • Appears dazed or stunned • Is confused about assignment or position • Forgets an instruction • Is unsure of game, score, or opponent • Moves clumsily • Answers questions slowly • Loses consciousness (even briefly) • Shows mood, behavior, or personality changes • Can't recall events prior to hit or fall • Can't recall events after hit or fall 	<ul style="list-style-type: none"> • Headache or "pressure" in head • Nausea or vomiting • Balance problems or dizziness • Double or blurry vision • Sensitivity to light or noise • Feeling sluggish, hazy, foggy, or groggy • Concentration or memory problems • Confusion • Just not "feeling right" or is "feeling down"

How can you help your teen prevent a concussion?

Every sport is different, but there are steps your teens can take to protect themselves from concussion and other injuries.

- Make sure they wear the right protective equipment for their activity. It should fit properly, be well maintained, and be worn consistently and correctly.
- Ensure that they follow their coaches' rules for safety and the rules of the sport
- Encourage them to practice good sportsmanship at all times.

What should you do if you think your teen has a concussion?

1. **Keep your teen out of play.** If your teen has a concussion, her/his brain needs time to heal. Don't let your teen return to play the day of the injury and until a health care professional, experienced in evaluating for concussion, says your teen is symptom-free and it's OK to return to play. A repeat concussion that occurs before the brain recovers from the first – usually within a short period of time (hours, days, or weeks) – can slow recovery or increase the likelihood of having long-term problems. In rare cases, repeat concussions can result in edema (brain swelling), permanent brain damage, and even death.
2. **Seek medical attention right away.** A health care professional experienced in evaluating for concussion will be able to decide how serious the concussion is and when it is safe for your teen to return to sports.
3. **Teach your teen that it's not smart to play with a concussion.** Rest is key after a concussion. Sometimes athletes wrongly believe that it shows strength and courage to play injured. Discourage others from pressuring injured athletes to play. Don't let your teen convince you that s/he's "just fine".
4. **Tell all of your teen's coaches and the student's school nurse about ANY concussion.** Coaches, school nurses, and other school staff should know if your teen has ever had a concussion. Your teen may need to limit activities while s/he is recovering from a concussion. Things such as studying, driving, working on a computer, playing video games, or exercising may cause concussion symptoms to reappear or get worse. Talk to your health care professional, as well as your teen's coaches, school nurse, and teachers. If needed, they can help adjust your teen's school activities during her/his recovery.

Parent/Guardian's Name (Please print) _____ Date _____, 20____

Parent/Guardian's Signature _____ Date _____, 20____

THIS FORM MUST BE SIGNED ANNUALLY AND MUST BE AVAILABLE FOR INSPECTION AT THE SCHOOL

**SOUTH DAKOTA HIGH SCHOOL ACTIVITIES ASSOCIATION
ANNUAL PARENT OR GUARDIAN PERMIT**

I hereby give my consent for _____ GRADE _____
Name (Please Print) 2017-18 SCHOOL YEAR
who was born at _____ on _____
City, Town, County, State Date of Birth
to compete in SDHSAA approved athletics for _____ High School during the 2017-18 school year.

I/We give our permission for our son/daughter to participate in organized high school athletics, realizing that such activity involves the potential for injury which is inherent in all sports.

Signed _____ Date _____, 20____
Parent or Legal Guardian

THIS FORM MUST BE COMPLETED ANNUALLY AND MUST BE AVAILABLE FOR INSPECTION AT THE SCHOOL.

INTERIM PRE-PARTICIPATION HISTORY
(Used in conjunction with the Biennial/Triennial examination.)

**SEE REVERSE SIDE FOR
HEALTH HISTORY QUESTIONNAIRE**

INTERIM PRE-PARTICIPATION HISTORY

(Used in conjunction with the Biennial/Triennial examination.)

NAME _____ GRADE _____ DATE OF BIRTH _____
 (2017-18 School Year)

IN THE PAST YEAR: YES NO

		YES	NO
1.	Has a doctor denied your participation in sports for any reason?		
2.	Do you have a new ongoing medical condition (like diabetes or asthma)?		
3.	Are you currently taking any new prescription or non-prescription (over-the-counter) medicines or pills?		
4.	Do you have new allergies to medicines, pollens, foods, or stinging insects?		
5.	Have you passed out or nearly passed out DURING exercise?		
6.	Have you passed out or nearly passed out AFTER exercise?		
7.	Have you had discomfort, pain, or pressure in your chest during exercise?		
8.	Has your heart raced or skipped beats during exercise?		
9.	Has a doctor told you that you have a heart murmur, high blood pressure, high cholesterol, or a heart infection?		
10.	Has a doctor ordered a test for your heart? (for example: ECG, echocardiogram)		
11.	Has anyone in your family died for no apparent reason?		
12.	Have you spent the night in a hospital?		
13.	Have you had surgery?		
14.	Have you had an injury, like a sprain, muscle or ligament tear, or tendonitis, that required medical attention?		
15.	Have you had any broken or fractured bones or dislocated joints?		
16.	Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches?		

YES NO

		YES	NO
17.	Have you had a stress fracture?		
18.	Did a doctor tell you that you have asthma or allergies?		
19.	Have you started to cough, wheeze, or have difficulty breathing during or after exercise?		
20.	Have you used an inhaler or taken asthma medicine?		
21.	Have you lost a kidney, an eye, a testicle, or any other organ?		
22.	Do you have any new rashes, pressure sores, or other skin problems?		
23.	Have you had a new herpes skin infection?		
24.	Have you had a head injury or concussion?		
25.	Have you been hit in the head and been confused or lost your memory?		
26.	Have you had a seizure?		
27.	Have you experienced headaches with exercise?		
28.	Have you had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
29.	Have you been unable to move your arms or legs after being hit or falling?		
30.	When exercising in the heat, did you have severe muscle cramps or become ill?		

Explain "Yes" answers here: _____

(continue on front side of this form if necessary)

RECERTIFICATION OF HEALTH

As the parent/guardian, I herewith affix my signature and certify that the above named student is physically fit to participate in interscholastic athletics for the current school year insofar as all "Yes" responses are concerned.

_____, 20_____
 Date

 Signature of Parent



Student-Athlete Authorization and Consent Form for Disclosure of Protected Health Info

I hereby authorize the athletic trainer and other health care personnel representing _____, (name of school) to release information regarding the student-athlete's protected health information and related information regarding any injury or illness during the student-athlete's training for and participation in athletics at the above named school. I further understand that it is at my request to comply with the requirements of his/her school and the release of protected health information to a coach, athletic director, or school official in connection with participation in interscholastic sports. This protected health information may concern the student-athlete's medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable health information. This protected information may be released to other health care providers, hospital and/or medical clinics and laboratories, athletic coaches, medical insurance coordinators, athletic and/or school administrators, chaplains and/or clergy members, and officials of the WCAL and CIF.

I, _____, parent and/or guardian of _____, student-athlete, understand that as a parent/guardian give authorization/consent for the disclosure of the undersigned student-athlete's protected health information is a condition for participation as an interscholastic athlete at the above named school. I understand that my protected health information may be protected by the federal regulations under the Health Information Portability and Accountability Act (HIPAA) and, if so, may not be disclosed without either parent/legal guardian authorization under HIPAA. This authorization/consent expires one year from the date it is signed.

Important: Your Rights. I understand my rights, as described herein:

- I may revoke this authorization at any time by notifying the above named school's Athletic Director in writing. My letter must be hand delivered or mailed to the School.
- A revocation will not affect any uses or disclosures that the above named school made before it received my revocation.
- If I request it, I may see a copy of the health information described on this form.
- The information that is used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA. I have the right to seek assurances from the above named entities or individuals authorized to receive the information that they will not re-disclose the information to any other party without my further authorization.

Consent for ImPACT and Release of Information

I give my permission for (name of child) _____ to have a baseline and post-concussion ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) as needed, administered at the above named school. I understand that my child may need to be complete ImPACT more than once post-concussion, depending upon the results, as compared to my child's baseline, which will be on file at the above named school. I understand there is no charge to complete the ImPACT.

The above named school may release the ImPACT results to my child's primary care physician, neurologist, team physician or other interpreting physician. I understand that as a parent/guardian, I give authorization/consent for the involved athletic trainer and/or health care personnel representing the above named school to contact the child's primary care physician, neurologist, team physician, or other treating physician, coach, athletic director, or school official regarding the results of the ImPACT

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

Print Student-Athlete's Name

Signature of Student-Athlete's Name

Date

Print Parent/Guardian Name

Signature Parent/Guardian Name

Date