Physical Evaluation Clearance Form

STUDENT'S NAME: _____

DATE OF BIRTH: _____

I plan to participate in:

____ Basketball	____ Football	____ Powerlifting	____ Tennis
____ Baseball	____ Golf	____ Rodeo	____ Track & Field
____ Bowling	____ Gymnastics	____ Soccer	____ Volleyball
____ Cross Country	____ Hockey	____ Softball	____ Wrestling
____ Dance	____ Horsemanship	____ Swimming & Diving	

PHYSICAL YEAR PAPERWORK (Print Neatly or Type)

Physical examination taken April 1 and thereafter is valid for the following two school years; physical examination taken before April 1 is valid only for the remainder of that school year and the following school year.

TO BE FILLED OUT BY LICENSED PHYSICIAN, APNP or PA:

Cleared without restriction, Cleared with recommendations for further evaluation or treatment for:

_____

Not cleared for all sports or just certain sports: _____

Reasons/Recommendations: _____

DATE of Examination: _____

Doctor, APNP or PA's Printed Name: _____

Signature: _____

Physicians may authorize Nurse Practitioners or Physician Assistants to stamp this card with the physician's signature or the name of the clinic with which the physician is affiliated.

Clinic Address or Stamp: _____

City _____ **State** _____ **Zip Code** _____ **Telephone** _____

Immunizations Up to date or Not up to date – specify:

_____

(e.g., tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis; pneumococcal; meningococcal;

Additional Signature Form

Warning of Inherent Risk and Parental Consent to Activity Participation

I understand and accept that there are certain inherent risks incumbent upon participation in activities including catastrophic outcomes, permanent disability and even death. Knowing this I hereby give the aforementioned student permission to participate in any activities sponsored by the Tomah Area School District and accept the consequences of such participation.

Parental or guardian consent must be granted annually for student-athlete participation. As parent or guardian, with your signature, you do hereby consent to allow the aforementioned student to engage in any extra-curricular activity sponsored by the Tomah Area School District during the present school year. I give permission for said athlete to be evaluated and treated by the Certified Athletic Trainer for injuries incurred during THS athletic participation. I further permit the Certified Athletic Trainer to discuss the injuries with appropriate medical and school district personnel. Furthermore, permission is granted this student to accompany the group/team, as a member, on out-of-town trips. It is understood that this child will also be expected to firmly adhere to all established school and activity code policies at all times.

Parent/Guardian Signature: _____ Date: _____

Limitation on Refusal to Disclose Directory Information/Media Release

I acknowledge that by providing permission for my son/daughter aforementioned to participate in the above referenced extracurricular activity(ies) that the school may take photographs and other reproductions of the activity and may use those reproductions in school newsletters, promotional materials, on its website, or may otherwise disseminate said photographs including identification of the students depicted. I also give permission for my son/daughter to be interviewed, mentioned, photographed, videotaped and quoted by the news media and employees of the Tomah Area School District before, during and after participation in an extra-curricular activity sponsored by the Tomah Area School District. This authorization is provided notwithstanding any opt-out election made with respect to student directory data.

Parent/Guardian Signature _____ Date _____

Equipment/Uniforms

I understand that I take full responsibility for all equipment issued to the above mentioned student including total reimbursement at replacement cost of any items lost, stolen or damaged beyond repair. The Tomah Area School District also reserves the right to charge a late return fee on equipment/uniforms of $3.00 per day for every day beyond the deadline set by the Coach, Advisor, or Activities Director.

Parent/Guardian Signature _____ Date _____

OVER>>>>>

Activities Code (Attached or Available online)

I have read and understand the Tomah Area School District Activities Code. I agree to abide by and support the code of conduct as a Tomah Area School District Extra-Curricular Participant/Parent/Guardian. I also understand that the Activities Code is in effect twelve months a year.

Student Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Once this is signed it will stay on file in the Activities Office, and it will stay in effect until the student completes 8th grade for Middle School students and 12th grade for High School Students.

Wisconsin Interscholastic Athletic Association Eligibility Form (Attached or Available online)

I have read and understand the WIAA Eligibility Form. I agree to abide by all WIAA rules and regulations as they apply to athletic participation while I am a student in the Tomah Area School District. I also understand that the WIAA rules are in effect twelve months a year.

Student Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

Transportation to off- Campus Facilities (High School 9th-12th graders ONLY)

Parent's Initial AND Circle Yes or No for each:

1. I hereby agree to allow the above named student to **drive** to and from off campus athletic/activity facilities.
   Circle: YES NO Initial _____

2. I hereby agree to allow the above named student to **transport other students** to off campus athletic/activity facilities. **(If yes, then the Student Section below must be completed.)**
   Circle: YES NO Initial _____
   a. I understand that the above named student may only transport the number of student passengers in which seatbelts are available in the vehicle he/she is driving.
      Circle: YES NO Initial _____

   b. I understand that liability follows my vehicle and my personal insurance will be the primary policy in the event of an accident. The school's policy will provide excess coverage when my personal insurance policy limits are reached.
      Circle: YES NO Initial _____

3. I hereby agree to allow the above named student to **ride** to and from off campus athletic/activity facilities utilizing transportation provided by another student.
   Circle: YES NO Initial _____

Parent/Guardian Signature: _____ Date: _____

Student Section (Must Be Completed if #2 Above is Checked Yes)

As a student driver/transporter, I agree to follow the route to and from the off-campus facility as designated by my teacher/advisor. I agree to go directly from the school to the off campus facility and, upon completion of my assignment, report directly back to Tomah High School. I further agree to follow all driver's license restrictions and abide by all local, state, and federal laws while transporting myself and/or others to off campus facilities. I also verify that the vehicle I drive is properly insured.
Insurance Company: _____ Policy Number: _____

Student Signature: _____ Date: _____

ImPACT™ BASELINE TESTING CONSENT FORM

Dear Parent/Guardian,

Your team or sports organization is currently utilizing an innovative program for evaluating and treating head injuries (e.g., concussion). In order to better manage concussions sustained by our student-athletes, your team or sports organization has partnered with Gundersen Sports Medicine to acquire a software tool called ImPACT™ (Immediate Post Concussion Assessment and Cognitive Testing). Headquartered in Pittsburgh, PA, ImPACT™ is a leader in computerized neurocognitive assessment tools and services. ImPACT™ has created an international network of clients who utilize the company's concussion management program. Neurocognitive tests such as ImPACT™ are an effective tool in recognizing and managing head injuries. Additional information about ImPACT™ can be found at www.impacttest.com.

Your team or sports organization is having student-athletes take the computerized exam before beginning contact sport practice or competition. The format of the test is similar to that of a video game and takes about 20-30 minutes to complete. The ImPACT™ test is akin to a pre-season physical of the brain. It tracks information such as memory, reaction time, and concentration, but it is not an IQ test. The ImPACT™ test is non-invasive and poses no risks to your child.

If your child suffers a head injury, and a concussion is suspected, your child will be referred to a health care organization for evaluation. The physician or clinician may recommend that your child take the post-injury ImPACT™ test. The health care organization will maintain your child's pre-season and post-injury test data, if any, on a secure server maintained by ImPACT™. Your child's post-test data will only be available to that health care organization, except as described below. If your child suffers a head injury, you will be contacted with additional details about how to proceed.

Your child's test data may be made available to the clinician evaluating your child. This clinician may choose to make your child's test data available to other health care providers who are being consulted regarding the treatment of your child. Your child's health and safety are at the forefront of the student athletic experience, and we are excited to utilize this program. If you have any further questions regarding this program please feel free to contact the provider testing your child.

Sincerely,

Gundersen Sports Medicine
3111 Gundersen Drive, Mailstop NC1-002
Onalaska, Wisconsin 54650
800-362-9567 ext. 58600

Gundersen Sports Medicine
111 Riverfront Building (Lafayette/Walnut Streets)
Winona, Minnesota 55987
800-362-9567 ext. 22360

PERMISSION SLIP

For use of the Immediate Post-Concussion Assessment and Cognitive Testing (ImPACT™)

I have read and understood the above information and give permission for my son/daughter to take the ImPACT™ Baseline Concussion Test.

Printed Name of Athlete _____ Grade _____

Signature of Athlete _____ Date _____

Signature of Parent _____ Date _____

DEFINITION OF A BRAIN CONCUSSION

A concussion is an injury to the brain caused by an "impulsive" force transmitted to the head, such as a direct blow to the head, collision, fall, whiplash injury or violent blow to the body. A concussion causes temporary impairment of normal brain function. Symptoms of head injury may not appear for several hours after trauma and frequently evolve over the first several days. The alteration of brain function can present as any number of signs and/or symptoms, such as those listed on this sheet. A person does NOT have to lose consciousness to have a concussion.

Every head injury should be taken seriously and each dealt with appropriately. No two are exactly alike. The effects of head injuries can be cumulative and recovery time from one to the next is frequently longer.

WHEN TO GO TO THE HOSPITAL

While not every concussed athlete needs to be evaluated emergently, every athlete suspected of having a concussion should be evaluated by a licensed medical provider. Should the athlete display any of the symptoms below, immediate transport to a hospital emergency department is advisable:

- Any loss of consciousness (LOC) or unresponsiveness
- Irregular vital signs (heart rate, breathing, blood pressure, etc.)
- Repeated vomiting
- Amnesia or worsening headache
- Seizure activity
- Persistent or worsening confusion or irritability
- Suspicion of a spine injury, skull fracture or bleeding

Keep careful watch over the athlete for several days. While sleeping the first night, you may wake the athlete periodically every 2-3 hours to determine if they are coherent and respond well to instructions; especially if they suffered LOC, prolonged amnesia or if still experiencing significant symptoms. Transport the athlete to the nearest hospital emergency department immediately if any of the following symptoms persist or worsen:

- Difficulty in waking the athlete
- Severe headache, particularly at a specific location, which is continuing, increasing or changing in pattern
- Dizziness or disorientation
- Blurred vision
- Pupils which are dilated, unequal in size, or non-reactive to light
- Poor balance or unsteadiness
- Difficulty in remembering relevant people, events or facts
- Deteriorating level of consciousness or convulsions
- Unusual or bizarre behavior
- Any discharge from the ears or nose
- Slurring of speech
- Confusion, strangeness or irritability
- Weakness or numbness in either arm or leg

The appearance of any of the above symptoms indicates that this athlete has a significant head injury that requires immediate medical attention. The recommendations on this document are in no way a substitute for the direct care of a licensed medical provider.

Other symptoms frequently observed in concussion include:

- Headache
- Nausea/vomiting
- Balance problems/dizziness
- Fatigue/drowsiness
- Changes in sleep patterns
- Sensitivity to light and/or noise
- Sadness/depression
- Nervousness/anxiety
- Emotional instability or irritability
- Numbness or tingling sensations
- Feeling mentally 'foggy' or slowed down
- Difficulty with concentration or memory
- Visual problems

INITIAL TREATMENT

After being assessed, the main treatment for concussion is rest, both physical and mental. Attempting to carry out one's normal activities while concussed will likely only prolong symptoms and slow recovery.

Activities to avoid or moderate while symptomatic include, but are not limited to: any physical activity, school attendance, using a computer, reading or studying, text messaging and video gaming. **The athlete should not be allowed to operate a motor vehicle.** Any other activities that exacerbate symptoms should also be curtailed or eliminated until the athlete is cleared to reintroduce the aggravating activity by his/her licensed medical provider.

Once symptoms are absent at rest, brief periods of reading, focusing and abbreviated school attendance may be better tolerated. Once the athlete can tolerate a full day of school, light intensity, low impact walking may be attempted.

PAIN RELIEF SUGGESTIONS

If pain medication is necessary, acetaminophen (Tylenol®) may be advisable. If pain cannot be effectively managed with acetaminophen, the athlete should seek care from a licensed medical provider. Cold packs may also offer some pain relief.

The use of anti-inflammatory drugs such as ibuprofen, naproxen or aspirin is not recommended for use when a concussion is suspected.

GENERAL RETURN TO PLAY RECOMMENDATIONS

It is imperative that no athlete resumes any physical activity until completely symptom free for several days. The athlete should be cleared by a licensed medical provider and his/her progress monitored by a licensed athletic trainer. When a return to sport is appropriate, a standardized post-concussion return to activity progression over several days is recommended.

If symptoms return at any time during this progression, activities should be stopped for the day. Symptoms should be reported to the supervising licensed medical provider. The athlete is advised to resume the progression once an asymptomatic status has been re-achieved. Athletes should be able to comfortably complete several full practice sessions before returning to play in games or matches.

Returning too soon can slow the recovery process, increase the chances of re-injury and risk permanent disability or death.

SAMPLE RETURN TO ACTIVITY PROTOCOL

The program below represents a minimum time table to return athletes back to competition. When utilized for an athlete's first concussion, Steps 2-7 take a minimum of six days to complete. A longer asymptomatic period and/or exercise progression is advisable if 1) complications arise 2) the program is utilized after a complex concussion or 3) the athlete has a history of multiple concussions.

Step 1: Athlete is symptom free for at least 48 hours, is caught up in all classes, and can tolerate a full academic schedule

Step 2: Light cardiovascular work (15 minutes on stationary bike)

Step 3: Light cardiovascular work (15 minutes bike + 15 minutes other non-impact light aerobic activity)

Step 4: Step 3 activities + Valsalva type activities (25 repetitions of sit-ups, push-ups and/or single leg squats)

Step 5: Step 4 activities + non-contact, sport specific drills in a practice setting for no more than 45-60 minutes

Step 6: Sport specific drills and conditioning without contact (attempt a full practice length, all team activities not involving hitting, contact or body jarring maneuvers)

Step 7: Attempt a full return to normal play, activities and/or physical education classes

WISCONSIN DEPARTMENT OF PUBLIC INSTRUCTION

PARENT & ATHLETE AGREEMENT

Related to Concussion Law WI Stat. 118.293

As a Parent and as an Athlete it is important to recognize the signs, symptoms, and behaviors of concussions. By signing this form you are stating that you understand the importance of recognizing and responding to the signs, symptoms, and behaviors of a concussion or head injury. *This form must be on file for every sports season and every youth athletic organization the athlete is involved with and must be renewed each school year (clubs- every 365 days).*

Parent Agreement:

I _____ have **read** the Parent Concussion and Head Injury Information and **understand** what a concussion is and how it may be caused. I also understand the common signs, symptoms, and behaviors. I agree that my child must be removed from practice/play if a concussion is suspected.

I understand that it is my responsibility to seek medical treatment if a suspected concussion is reported to me.

I understand that my child cannot return to practice/play until providing written clearance from an appropriate health care provider to his/her coach.

I understand the possible consequences of my child returning to practice/play too soon.

Parent/Guardian
Signature_____Date_____

Athlete Agreement:

I_____have **read** the Athlete Concussion and Head Injury Information and **understand** what a concussion is and how it may be caused.

I understand the importance of reporting a suspected concussion to my coaches and my parents/guardian.

I understand that I must be removed from practice/play if a concussion is suspected. I understand that I must provide written clearance from an appropriate health care provider to my coach before returning to practice/play.

I understand the possible consequence of returning to practice/play too soon and that my brain needs time to heal.

Athlete
Signature_____Date_____

WISCONSIN DEPARTMENT OF PUBLIC INSTRUCTION
125 South Webster Street,
PO Box 7841,
Madison, WI 53707-7841
PHONE 608-266-3390
TOLL FREE 800-441-4563
WEB SITE http://www.dpi.wi.gov

Questions and Contact Information

Related to Concussion Law WI Stat. 118.293

Name_____**Date**_____

Address_____

City_____**Zip**_____**County**_____

Phone_____**Email**_____

Age_____**School** _____**School District**_____

Check all that apply
I participate in:

O Football	**O Baseball/Softball**	**O Basketball**	**O Hockey**
O Soccer	**O Golf**	**O Volleyball**	**O Wrestling**
O Track & Field	**O Cross Country**	**O Cheerleading**	**O Skiing/Snowboarding**
O Gymnastics	**O Tennis**	**O Swimming & Diving**	

O Other_____

Name of Current Team_____

1. Have you ever had a concussion?_____, if yes, how many?_____

2. Have you ever experienced concussion symptoms?_____Did you report them?_____

Emergency Contacts:

Name: _____ **Relationship:** _____

Phone Number: _____

Name: _____ **Relationship:** _____

Phone Number: _____

Please complete this form and return to the person operating the youth athletic activity.

Athletics/Activities Participation Release Form

Student Name: (Last) _____ (First) _____ (Middle) _____
Date of Birth: _____ School Attending: _____
GRADE: Circle one - 6th 7th 8th 9th 10th 11th 12th Age: _____
GENDER: Circle one - Male - Female
Parent/Guardian Name(s): _____
Student/Parent/Guardian Address: Number & Street_____ City_____
Phone Number at Above Address: _____ - _____
Known Allergies to Drugs or Anesthetics: _____
Pre-Existing Conditions i.e. asthma, epilepsy, diabetes: _____
Current Medications: _____
Family Doctor/Clinic Name and Phone Number: _____, _____ - _____
Family Dentist/Clinic Name and Phone Number: _____, _____ - _____

Emergency Contact/Medical Treatment Consent

In case of emergency, contact:
1._____at home (_____-_____) at work (_____-_____) or cell (_____-_____)
(Parent/Guardian)
2._____at home (_____-_____) at work (_____-_____) or cell (_____-_____)
(Parent/Guardian)
3._____at home (_____-_____) at work (_____-_____) or cell (_____-_____)
(Adult Relative/Friend)

The parent or guardian of a Tomah Area School District student participant recognizes that as a result of participation, medical treatment on an emergency basis may be necessary. The participants' parent or guardian further recognizes that school personnel may be unable to contact them for their consent for emergency medical care. The Tomah Area School District does hereby secure parent/guardian consent in advance to such emergency care, including hospital care, as may be deemed necessary under the then existing circumstance. Pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated there under (collectively known as "HIPAA"), I authorize health care providers of the student named above, including emergency medical personnel and other similarly trained professionals that may be attending an event or practice, to disclose or exchange essential medical information regarding the injury and treatment of this student to appropriate school district personnel such as but not limited to: Principal, Athletic Director, Athletic Trainer, Team Physician, Team Coach, Administrative Assistant to the Athletic Director and/or other professional health care providers, for purposes of treatment, emergency care and injury record-keeping.

Parent/Guardian Signature _____ Date _____

Insurance Information

I, the parent or guardians of the above mentioned student have insurance on said student through:

Company Name or "NONE": _____ Policy Number: _____.

Parent/Guardian Signature: _____

TO BE FILLED OUT BY ACTIVITIES DIRECTOR OR A.D. SECRETARY:

The above-mentioned student has turned in the necessary paperwork and can participate in athletics and activities for the current school year.

_____ _____
Signature of Activities Director Date

TO BE FILLED OUT BY COACH/ADVISOR:

		Sport	All Equip. Turned In	Finished as Member of Team Yes/No	Uniform Numbers	Coach Initials
Return to A.D. when:	FALL					
1. Student did not finish season (DNF-Sport/Activity)	WINTER					
2. Season is over and all equip. etc. has been turned in.	SPRING					

Gold Copy: Coach gets from AD
Pink Copy: Athletic Trainer