WMMS/FCS
6/7/8 Grade

Student-Athlete COVID Questionnaire

Student-Athlete's Name: _____

Date of Birth: _____ Age: _____

COVID RELATED QUESTIONS ABOUT THE STUDENT-ATHLETE	YES	NO	NA
1. Since January 1, 2020 have you been told that you have had a positive test for COVID-19, **OR** have you been told by a medical professional, your school, or local health department that you have had to quarantine (stay home) due to concern that you had COVID-19 symptoms?			
2. If the answer to 1 was "Yes", has the required *Return to Play Form: COVID-19 Infection Medical Clearance Releasing The Student-Athlete to Resume Full Participation in Athletics* been completed?			
3. Have you been fully vaccinated against COVID?			

Parent/student

■ PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex: M/F _____

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 your allergies (ie, 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? (**check box next to appropriate number**)*

	Not at all	Several days	Over half the days	Nearly every day
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

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	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, flutter in your chest, 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 requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.	☐	☐

HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)	Yes	No
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 years (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?	☐	☐

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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 *Staphylococcus aureus* (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?	☐	☐

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
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?		

Explain "Yes" answers here.

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 or guardian: _____

Date: _____

Doctor

■ PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

1. Consider additional questions on more-sensitive issues.
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)	☐	
Eyes, ears, nose, and throat • Pupils equal • Hearing	☐	
Lymph nodes	☐	
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)	☐	
Lungs	☐	
Abdomen	☐	
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis	☐	
Neurological	☐	
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck	☐	
Back	☐	
Shoulder and arm	☐	
Elbow and forearm	☐	
Wrist, hand, and fingers	☐	
Hip and thigh	☐	
Knee	☐	
Leg and ankle	☐	
Foot and toes	☐	
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test	☐	

[a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

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■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

_____

_____

☐ Medically eligible for certain sports

_____

_____

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: _____

_____

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are 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 medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: _____

_____

_____

Medications: _____

_____

_____

Other information: _____

_____

_____

Emergency contacts: _____

_____

_____

Parent / Student

Gfeller-Waller NCHSAA Student-Athlete & Parent/Legal Custodian Concussion Statement Form

Instructions: The student athlete and his/her parent or legal custodian, must initial beside each statement acknowledging that they have read and understand the corresponding statement. The student-athlete should initial in the left column and the parent or legal custodian should initial in the right column. Some statements are applicable only to the student-athlete and should only be initialed by the student-athlete. This form must be completed for each student-athlete, even if there are multiple student-athletes in the household.

Student-Athlete Name: (please print)_____

Parent/Legal Custodian Name(s): (please print)_____

Student-Athlete Initials		Parent/Legal Custodian(s) Initials
	A concussion is a brain injury, which should be reported to my parent(s) or legal custodian(s), my or my child's coach(es), or a medical professional if one is available.	
	A concussion cannot be seen. Some signs and symptoms might be present immediately; how[illegible] hours or days after an injury.	
	I will tell my paren[illegible] about my injuries and illnesses.	Not Applicable
	If I think a teamm[illegible]es), parent(s)/ legal custodian(s) or medical professional about the concussion.	Not Applicable
	I, or my child, will [illegible] to my, or my child's, head or body caus[illegible]	
	I, or my child, wil[illegible]fessional trained in concussion manag[illegible]ussion.	
	Based on the late[illegible]ks to get better. A concussion may n[illegible] from a concussion is a process that n[illegible]	
	I realize that ER/U[illegible]nce to return to play or practice, if seen[illegible]	
	After a concussion, [illegible] that I or my child is much more likely to h[illegible] brain injury if return to play or practice occurs [illegible]ay.	
	Sometimes, repeat concus[illegible]ong-lasting problems.	
	I have read the concussion symptoms listed on the Student-Athlete/ Parent Legal Custodian Concussion Information Sheet.	
	I have asked an adult and/or medical professional to explain any information contained in the Student-Athlete & Parent Concussion Statement Form or Information Sheet that I do not understand.	

By signing below, we agree that we have read and understand the information contained in the Student-Athlete & Parent/Legal Custodian Concussion Statement Form, and have initialed appropriately beside each statement.

_____ _____

Signature of Student-Athlete Date

_____ _____

Signature of Parent/Legal Custodian Date

What is a concussion? A concussion is an injury to the brain caused by a direct or indirect blow to the head. It results in your brain not working as it should. It may or may not cause you to black out or pass out. It can happen to you from a fall, a hit to the head, or a hit to the body that causes your head and your brain to move quickly back and forth.

How do I know if I have a concussion? There are many signs and symptoms that you may have following a concussion. A concussion can affect your thinking, the way your body feels, your mood, or your sleep. Here is what to look for:

Thinking/Remembering	Physical	Emotional/Mood	Sleep
Difficulty thinking clearly	Headache	Irritability-things bother you more easily	Sleeping more than usual
Taking longer to figure things out	Fuzzy or blurry vision	Sadness	Sleeping less than usual
Difficulty concentrating	Feeling sick to your stomach/queasy	Being more moody	Trouble falling asleep
Difficulty remembering new information	Vomiting/throwing up	Feeling nervous or worried	Feeling tired
	Dizziness	Crying more	
	Balance problems		
	Sensitivity to noise or light		

Table is adapted from the Centers for Disease Control and Prevention (http://www.cdc.gov/concussion/)

What should I do if I think I have a concussion? If you are having any of the signs or symptoms listed above, you should tell your parents, coach, athletic trainer or school nurse so they can get you the help you need. If a parent notices these symptoms, they should inform the school nurse or athletic trainer.

When should I be particularly concerned? If you have a headache that gets worse over time, you are unable to control your body, you throw up repeatedly or feel more and more sick to your stomach, or your words are coming out funny/slurred, you should let an adult like your parent or coach or teacher know right away, so they can get you the help you need before things get any worse.

What are some of the problems that may affect me after a concussion? You may have trouble in some of your classes at school or even with activities at home. If you continue to play or return to play too early with a concussion, you may have long term trouble remembering things or paying attention, headaches may last a long time, or personality changes can occur Once you have a concussion, you are more likely to have another concussion.

How do I know when it's ok to return to physical activity and my sport after a concussion? After telling your coach, your parents, and any medical personnel around that you think you have a concussion, you will probably be seen by a doctor trained in helping people with concussions. Your school and your parents can help you decide who is best to treat you and help to make the decision on when you should return to activity/play or practice. Your school will have a policy in place for how to treat concussions. You should not return to play or practice on the same day as your suspected concussion.

This information is provided to you by the UNC Matthew Gfeller Sport-Related TBI Research Center, North Carolina Medical Society, North Carolina Athletic Trainers' Association, Brain Injury Association of North Carolina, North Carolina Neuropsychological Society, and North Carolina High School Athletic Association.

Parent/student

Waiver of Basic Insurance Coverage for Participating in School Athletics

The undersigned agrees and certifies that:

1. He/She is the parent or legal guardian of _____ (hereafter referred to as "student"), date of birth _____, who will be a student at West McDowell Middle School during the _____academic year.
2. The undersigned has legal custody of the student, or other legal authority to obtain insurance coverage for the student, and has consent to the student's participation in the school's athletic programs.
3. The undersigned understands that medical, hospital, and/or other legal authority to obtain insurance coverage for athletic injuries can be obtained through the school, but the school must pass the costs of such coverage on the parents or guardian of the students who are financially able to bear such costs.
4. The student is covered by an existing insurance policy with _____which provides medical, hospital, and/or other basic coverage for injuries which the student might receive while participating in the school's athletic program.
5. THE UNDERSIGNED AGREES TO PROVIDE BASIC INSURANCE COVERAGE FOR THE STUDENT THROUGH THE INSURANCES NAMED ABOVE -- AND TO WAIVE ANY INSURANCE COVERAGE (other than catastrophic insurance, which provides coverage only for claims in excess of $25,000 are not covered by other insurance) WHICH THE SCHOOL MIGHT OTHERWISE OBTAIN.
6. The undersigned agrees to notify the school immediately if the student's insurance coverage is canceled or otherwise terminated; the undersigned further agrees that no claim will be made against McDowell County School system for failure of the school system to obtain basic insurance coverage for the student.
7. The undersigned agrees to release the school and McDowell County Schools of any responsibility for personal injury and/or financial liability for any injuries which occur while the student is participating in school sanctioned athletic events and activities.

This the _____day of_____, _____.

_____

Parent or legal guardian name printed

_____

Parent or guardian signature

there is a backside to this document

Emergency/Medical Treatment

I hereby certify that _____ has our permission to participate in school sports activities and related travel, if the student is accompanied by an adult representation of the team (i.e. coach, athletic director, athletic trainer) the above signed student may receive medical treatment if deemed necessary by a physician without parent contact.

I (we) acknowledge that this document empowers physicians or staff on call to administer necessary and prudent treatment without prior contact when a student is accompanied by an adult representative (coach, athletic director, athletic trainer).

_____. _____.

Father/legal guardian Date

_____. _____.

Mother/legal guardian Date

(both parents should sign if at all possible)

Thank you,
West McDowell Athletics

Parent/Student

Sports Medicine Program Consent for Medical Care and Treatment

I, , the parent/legal guardian of,, a student at (the "School") whose date of birth is , authorize and MH Hospital Manager, LLC each of its affiliated, participating hospitals as applicable including MH Mission Hospital, LLLP, MH Blue Ridge Medical Center, LLLP, MH Transylvania Regional Hospital, LLLP, MH Mission Hospital McDowell, LLLP, MH Angel Medical Center, LLLP, and MH Highlands-Cashiers Medical Center, LLLP (collectively and/or individually as is applicable referred to herein as "Mission") and associated staff to provide my child such healthcare or other services offered by the Sports Medicine Program and, where appropriate, to make referrals for my child to receive additional health services that my child's condition may indicate. *In any such event, student athletes and their parents/legal guardians shall have the option to choose any medical provider as they and/or their legal guardian(s) may choose, as many options are available to student athletes. No student and/or his or her parents/guardians are required to utilize Mission for medical services.*

Pre-Participation Physical. I hereby give my consent/permission to Mission and participating, licensed or other medical providers to perform a pre-participation screening physical examination ('screening exam") for my child. I agree that this screening exam is only a limited, screening examination and does not take the place of a complete medical examination. I understand and agree that the medical provider(s) completing the screening exam shall not be responsible for any ongoing medical care or treatment for any medical condition or for injuries that occur after the screening exam. I represent, to the best of my knowledge, that my child has no known medical condition that would prevent participation in sports. I agree to follow up with my child's primary care provider in the event that any medical condition is identified in the screening exam.

Injury and/or Emergency Treatment: In the event that it becomes necessary, I agree that the team physician or athletic trainer, as appropriate, may provide medical care and/or treatment to my child as provided herein for a sports-related injury. In addition, in the event my child needs urgent or emergency treatment, I authorize the staff of the School and/or Mission, where appropriate, to arrange for such care with appropriate providers, including appropriate transportation. In such instance, I authorize the School and/or Mission, where appropriate, to undertake any acts which may be necessary or proper to provide for the health care of the minor child named herein, including, but not limited to, the power (i) to provide for such health care at any hospital or other institution, or the employing of any physician, dentist, nurse, or other person whose services may be needed for such health care, and (ii) to consent to and authorize any health care, including administration of anesthesia, X-ray examination, performance of operations, and other procedures by physicians, dentists, and other medical personnel except the withholding or withdrawal of life sustaining procedures. By signing below, I indicate that I have the understanding and capacity to communicate health care decisions on behalf of the child named herein and that I understand the contents of this document. I understand that the School staff and/or the Mission staff, as appropriate, will contact me as soon as possible in the event my child has an urgent or emergency condition.

Payment for Services Rendered. I understand that I will not be charged by Mission for services rendered on-site by the Mission Athletic Trainer or other Mission Sports Medicine staff assigned to the school but that I or my insurance carrier may be charged for services rendered by other healthcare providers for follow-up care or treatment.

Health Information. I agree to complete all health history, family history, and other informational requests necessary for my child's participation in the School's athletic events and as required for medical care and treatment or other services provided by Mission. I understand that I may contact the Mission Athletic Trainer or the Team Physician assigned to the School or the Mission Medical Director to discuss my child's care or to discuss any questions that I may have about the program.

Neurocognitive Testing. I understand and agree that my child may undergo a computerized concussion evaluation system, such as ImPACT, as part of an overall concussion management protocol. https://www.impacttest.com/about

Students. I understand and agree that Mission is involved in the education of student athletic trainers (at the college level and student aides at the high school level), physicians, nurses, technicians and other health care providers, interns, and observers. I understand and agree that these individuals may participate as is appropriate in providing athletic training, medical care and/or treatment to my child as provided herein for a sports-related injury or otherwise.

Medication. Athletic Trainers are not responsible for an athlete's prescription or non- prescription medication(s). An athletic trainer may, under the supervision and protocol of a provider, receive, store, and administer medication to my child and/or store my child's medication for the duration of an athletic event upon my request.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND AGREE AND CONSENT TO MY CHILD'S PARTICIPATION IN THE MISSION SPORTS MEDICINE PROGRAM AND TO THE OTHER TERMS AND CONDITIONS CONTAINED HEREIN. I HEREBY CERTIFY THAT I AM THE PARENT OR LEGAL GUARDIAN OF THE CHILD NAMED HEREIN.

Name of Parent/Legal Guardian (Please Print) Name of Student (Please Print)

Signature of Parent/Legal Guardian Relationship to Student Date of Signature:

AUTHORIZATION FOR ACCESS, USE, OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I,_, the parent/legal guardian of , a student at (the "School") whose date of birth is , authorize MH Hospital Manager, LLC and each of its affiliated, participating hospitals as applicable including MH Mission Hospital, LLLP, MH Blue Ridge Medical Center, LLLP, MH Transylvania Regional Hospital, LLLP, MH Mission Hospital McDowell, LLLP, MH Angel Medical Center, LLLP, and MH Highlands Cashiers Medical Center, LLLP (collectively and/or individually as is applicable referred to herein as "Mission") consent to and authorize the release by Mission of information about my child's medical condition obtained through the Sports Medicine Program to the School's named coaches and other employees or agents of the School. I also specifically consent to and authorize the sharing of my child's medical information among the Mission Sports Medicine staff (team physicians, if any, other medical staff/providers, athletic trainers, and any student assistants) and the School's athletic staff, teachers/coaches, and school administration.

My signature below indicates that I understand and agree to the following:

1. This authorization for the release of my health information is voluntary, which means I do not have to authorize this release or sign this form.
2. As applicable, this release may include information related to behavioral/mental health, drug and alcohol abuse treatment, genetic information, HIV/AIDS, and other sexually transmitted diseases, unless limited by the above selections.
3. My decision to sign this authorization will not have an effect on the treatment provided to my child by any applicable health care provider, the cost of that treatment, or any benefits.
4. I may revoke this authorization at any time by notifying Mission in writing.
5. Revoking this authorization will not affect any disclosures made prior to revoking this authorization. 6. Unless revoked or an **expiration date** is indicated here_, this authorization will extend until the end of the athletic season for which my child is engaged (2020-2021) athletic year). 7. After release my information may no longer be protected by privacy regulations, which means the person receiving may be able to share that information without my permission.
8. Mission will not use or share my health information without my permission, except as allowed or required by law.
9. This form will not be used for marketing or research.
10. A fee may be charged for providing any requested medical records.
11. I may ask for and get a copy of this authorization. A readable photocopy/fax of this authorization shall have the same force and effect as the original.

I hereby authorize the access, use or disclosure of my child's health information as described in this form.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND AGREE TO THE TERMS AND CONDITIONS CONTAINED HEREIN. I HEREBY CERTIFY THAT I AM THE PARENT OR LEGAL GUARDIAN OF THE CHILD NAMED HEREIN.

Name of Parent/Legal Guardian (Please Print) Name of Student (Please Print)

Signature of Parent/Legal Guardian Relationship to Student

Date of Signature:

Parent/Student

MCDOWELL COUNTY SCHOOLS
FIELD TRIP AND EXTRACURRICULAR TRAVEL PARENTAL CONSENT FORM

Student Name: _____ Grade: _____

Mode of Transportation: Activity Bus Vehicle #: Various

Health Insurance Company: _____

Policy Holder: _____ Policy #: _____

I hereby give my permission for my child to participate in the field trip or extracurricular travel, and for a representative of McDowell County Schools to obtain medical assistance, and authorize medical treatment and any medical procedure which is in the best interest of my child whenever I am not readily available to grant such authority and permission directly to the doctor or hospital involved.

Signature: _____ Date: _____
Parent or Guardian

Telephone: _____
Home *Work* *Mobile*

Trip Approved By: WEST McDOWELL MIDDLE SCHOOL Date: _____
School Official

SPORTSMANSHIP AND CONDUCT STATEMENT

Sportsmanship is the quality of responsible behavior characterized by genuine concern for opponents, officials, and teammates. It is an essential ingredient of sound athletic competition. We will endeavor to be modest in victory and gracious in defeat. Athletes and coaches alike realize that they represent themselves, their teams, their school and their families. We will play fairly, compete hard, and play to win, always striving to do our best. We will show respect for our opponents and out teammates, our coaches and game officials, and out parents and fans. Our goal is to be the best we can be, always exhibiting good sportsmanship.

Athletes must strive to set a good example of behavior. Positive, respectful behavior in class, at school and away from school is essential. Parents must also be positive behavior role models for their students. Excessive violation of school rules, general disrespect and bad behavior will not be tolerated. Bad behavior by students and/or parents may result in dismissal from a team and/or dismissal from an event.

AS ATHLETES, WE PLEDGE TO:

1. Accept conscientiously the responsibility and privilege of representing the school and community.
2. Respect officials' judgments and interpretations of the rules.
3. Treat visiting athletes with the respect that is due them as guests and worthy opponents.
4. As a visitor to another school, remember that we are a guest. Show respect for our opponents' field, court and locker room.
5. Congratulate opponents in a sincere manner following either victory or defeat. Be modest in victory and gracious in defeat.
6. Exercise self-control at all times. Always use appropriate language. Refrain from taunting, intimidation and fighting.
7. Following and obey school rules. Show respect for other students. Show respect for teachers, administrators and other staff.
8. Refrain from disruptive and disrespectful behavior.

AS PARENTS AND / OR SPECTATORS, WE PLEDGE TO:

1. Realize that we are at a contest to support our team. We should recognize and compliment outstanding play.
2. Remember that school athletics are learning experiences for students. Praise student-athletes in their attempt to improve themselves as students and athletes.
3. Realize that attendance at athletic events is a privilege – not a license to verbally assault others, including officials, with intimidating language or actions.
4. Show respect for opposing players, fans, coaches and support groups.
5. Refrain from taunting or making any kind of derogatory remarks to our opponents during the game.
6. Respect officials' judgment and interpretations of the rules.
7. Refrain from the use of any controlled substances (alcohol, drugs, etc.) and tobacco products before games, during and after the games on or near the site of the event.

Signed: _____ _____
Parent or Guardian *Student Athlete*

2021-2022 WEST MCDOWELL MIDDLE SCHOOL ATHLETIC PARTICIPATION FORM

PLEASE PRINT

ATTENTION: BE SURE TO SIGN ALL EIGHT (8) THICK-BORDERED SIGNATURE BOXES

Name:_____ Male:_____ Female:_____
Last First Middle

Address: _____
Street City State Zip code

The student is domiciled at the above address located in the_____School District
(School must be notified if a student moves from the above address.)

You live with: _____
Name of Parent/Parents/Guardian

Telephone: _____
Home work Mobile

Emergency Contact: _____

Date of Birth: _____ Student #:_____ NC Wise ID

Grade Level for the 2021-22 School Year: _____

PARENT AND ATHLETE CONSENT FOR ATHLETIC PARTICIPATION

I/We certify that the home address of parents/guardians listed above is our sole bona fide residence and will notify the school principal immediately of any change in residence, since a move may after the eligibility status of the student-athlete. *I/We* certify that the student-athlete has not plead guilty to or been convicted of a felony. I/We certify that the student-athlete has not participated in a sport in another state during this school year.

***I/We* acknowledge that the use and/or possession of alcohol and illegal drugs violates Board** of Education policies.

1/ We acknowledge that there is a certain risk of injury involved with athletic participation. Even with the best coaching use of the most advanced protective equipment and strict observance of the rules, injuries are still a possibility and on rare occasions these can be so severe as to result in total disability, paralysis or even death. It is impossible to eliminate this risk.

As student-athletes and parents, by choosing to participate, you acknowledge the risk of injury and understand that you must adhere to the proper instruction about techniques and the use of equipment. You agree to refrain from improper uses or techniques.

I/We have read and reviewed the general requirements for Middle School athletic eligibility and the policies of McDowell County Schools athletics and agree to abide by those standards. We also acknowledge the risk outlined above and do hereby give our informed consent to allow the above named student to participate in all athletic activities at this school for this academic year.

Signed:_____ Date:_____
Parent or Guardian

Signed:_____ Date_____
Student Athlete