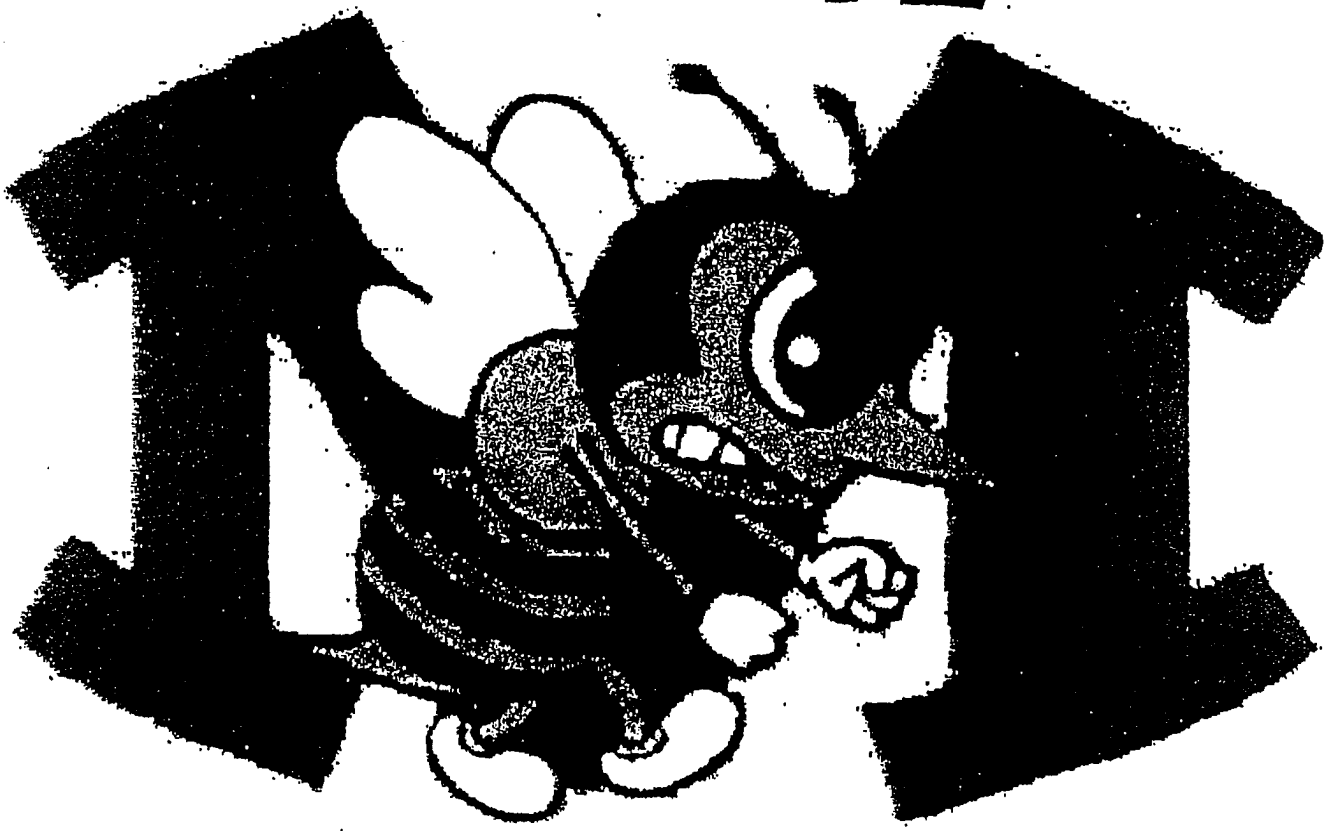
MONROE



HORNETS

ALL SPORTS INFORMATION PACKET

Participation Fee Process

1. Fee for participation in high school (9-12) sports is $250.00 per sport.

2. Fee for participation in junior high (7 & 8) sports is $200.00 per sport.

3. In sports that do not cut teams, all fees must be paid before participating in any regular season practice.

4. In sports that make cuts, all fees must be paid five (5) days after final cuts are made.

5. Athletes must pay fees to their coaches.

6. Hardship cases must make arrangements to see the Athletic Director to determine the status of the request.

7. There will be no refund of participation fees to any athlete who quits a team or becomes academically ineligible.

8. Injured athletes will have their fees pro-rated.

Monroe Local Schools

PARENT/STUDENT ACKNOWLEDGEMENT OF ACADEMIC ELIGIBILITY REQUIREMENTS

Academic eligibility requires that High School students (9-12) must maintain a 1.75 GPA and pass 5 one credit classes (excluding physical education) and Junior High students must pass and maintain a 1.75 GPA. The previous nine week grading period determines eligibility for current grading period.

It should be noted that dropping a class may result in losing your academic eligibility. You must maintain 5 core classes. It is always best to check with your principal or an athletic director to make sure that you remain eligible before you make any changes to your schedule.

_____ _____

Signature of Parent/Guardian Signature of Student

_____ _____

Date signed Date signed

Once signed, this form must be returned to the Athletic Department prior to the student being allowed to participate in the designated sport.

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Ohio High School Athletic Association

PREPARTICIPATION PHYSICAL EVALUATION 2012-2013

HISTORY FORM

(Note: This form is to be filled out by the student and parent prior to seeing the medical examiner. The medical examiner should keep this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list the prescription and over-the-counter medicines and supplements (herbal and nutritional-including energy drinks/ protein supplements) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS		Yes	No
1.	Has a doctor ever denied or restricted your participation in sports for any reason?		
2.	Do you have any ongoing medical conditions? If so, please identify below: Asthma Anemia Diabetes Infections Other: _____		
3.	Have you ever spent the night in the hospital?		
4.	Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU		**Yes**	**No**
5.	Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6.	Have you ever had discomfort, pain tightness, or pressure in your chest during exercise?		
7.	Does your heart ever race or skip beats (irregular beats) during exercise?		
8.	Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9.	Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10.	Do you get lightheaded or feel more short of breath than expected during exercise?		
11.	Have you ever had an unexplained seizure?		
12.	Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		**Yes**	**No**
13.	Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14.	Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arryhthmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15.	Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16.	Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS		**Yes**	**No**
17.	Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or game?		
18.	Have you ever had any broken or fractured bones or dislocated joints?		
19.	Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20.	Have you ever had a stress fracture?		
21.	Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22.	Do you regularly use a brace, orthotics, or other assistive device?		
23.	Do you have a bone, muscle, or joint injury that bothers you?		
24.	Do any of your joints become painful, swollen, feel warm, or look red?		
25.	Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS		Yes	No
26.	Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27.	Have you ever used an inhaler or taken asthma medicine?		
28.	Is there anyone in your family who has asthma?		
29.	Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30.	Do you have groin pain or a painful bulge or hernia in the groin area?		
31.	Have you had infectious mononucleosis (mono) within the past month?		
32.	Do you have any rashes, pressure sores, or other skin problems?		
33.	Have you had a herpes (cold sores) or MRSA (staph) skin infection?		
34.	Have you ever had a head injury or concussion?		
35.	Have you ever had a hit or blow to the head that caused confusion, prolonged headaches, or memory problems?		
36.	Do you have a history of seizure disorder or epilepsy?		
37.	Do you have headaches with exercise?		
38.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39.	Have you ever been unable to move your arms or legs after being hit or falling?		
40.	Have you ever become ill while exercising in the heat?		
41.	Do you get frequent muscle cramps when exercising?		
42.	Do you or someone in your family have sickle cell trait or disease?		
43.	Have you had any problems with your eyes or vision?		
44.	Have you had an eye injury?		
45.	Do you wear glasses or contact lenses?		
46.	Do you wear protective eyewear, such as goggles or a face shield?		
47.	Do you worry about your weight?		
48.	Are you trying to gain or lose weight? Has anyone recommended that you do?		
49.	Are you on a special diet or do you avoid certain types of foods?		
50.	Have you ever had an eating disorder?		
51.	Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY			
52.	Have you ever had a menstrual period?		
53.	How old were you when you had your first menstrual period?		
54.	How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

_____

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

Signature of Student _____ Signature of parent/guardian _____ Date: _____

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

1.	Type of disability		
2.	Date of disability		
3.	Classification (if available)		
4.	Cause of disability (birth, disease, accident/trauma, other)		
5.	List the sports you are interested in playing		
		Yes	No
6.	Do you regularly use a brace, assistive device or prosthetic?		
7.	Do you use a special brace or assistive device for sports?		
8.	Do you have any rashes, pressure sores, or any other skin problems?		
9.	Do you have a hearing loss? Do you use a hearing aid?		
10.	Do you have a visual impairment?		
11.	Do you have any special devices for bowel or bladder function?		
12.	Do you have burning or discomfort when urinating?		
13.	Have you had autonomic dysreflexia?		
14.	Have you ever been diagnosed with a heat related (hyperthermia) or cold-related (hypothermia) illness?		
15.	Do you have muscle spasticity?		
16.	Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

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

Signature of Student _____ Signature of parent/guardian _____ Date: _____

Ohio High School Athletic Association

PREPARTICIPATION PHYSICAL EVALUATION 2012-2013

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, 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 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 or use condoms?
   - Do you consume energy drinks?
2. Consider reviewing questions on cardiovascular symptoms (questions 5-14).

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat Pupils equal Hearing		
Lymph nodes		
Heart Murmurs (auscultation standing, supine, +/- Valsalva) Location of the point of maximal impulse (PMI)		
Pulses Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional Duck walk, single leg hop		

[a]Consider ECG, echocardiogram, or referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third part present is recommended.
[c]Consider cognitive or baseline neuropsychiatric testing if a history of significant concussion.

CLEARANCE FORM

Note: Authorization forms (pages 5 and 6) must be signed by both the parent/guardian and the student.

Name _____ Sex ☐ M ☐ F Age _____ Date of birth _____

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not Cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

  Reason _____

Recommendations _____

_____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The student 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. In the event that the examination is conducted en masse at the school, the school administrator shall retain a copy of the PPE. If conditions arise after the student 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 physician or medical examiner (print/type) _____ Date of Exam _____

Address _____ Phone _____

Signature of physician/medical examiner _____, MD, DO, D.C., P.A. or A.N.P.

EMERGENCY INFORMATION

Personal Physician _____ Phone _____

In case of Emergency, contact _____ Phone _____

Allergies _____

_____

_____

_____

_____

_____

Other Information _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

THE STUDENT SHALL NOT BE CLEARED TO PARTICIPATE IN INTERSCHOLASTIC ATHLETICS UNTIL THIS FORM HAS BEEN SIGNED AND RETURNED TO THE SCHOOL

OHSAA AUTHORIZATION FORM 2012-2013

I hereby authorize the release and disclosure of the personal health information of _____ ("Student"), as described below, to _____ ("School").

The information described below may be released to the School principal or assistant principal, athletic director, coach, athletic trainer, physical education teacher, school nurse or other member of the School's administrative staff as necessary to evaluate the Student's eligibility to participate in school sponsored activities, including but not limited to interscholastic sports programs, physical education classes or other classroom activities.

Personal health information of the Student which may be released and disclosed includes records of physical examinations performed to determine the Student's eligibility to participate in school sponsored activities, including but not limited to the Pre-participation Evaluation form or other similar document required by the School prior to determining eligibility of the Student to participate in classroom or other School sponsored activities; records of the evaluation, diagnosis and treatment of injuries which the Student incurred while engaging in school sponsored activities, including but not limited to practice sessions, training and competition; and other records as necessary to determine the Student's physical fitness to participate in school sponsored activities.

The personal health information described above may be released or disclosed to the School by the Student's personal physician or physicians; a physician or other health care professional retained by the School to perform physical examinations to determine the Student's eligibility to participate in certain school sponsored activities or to provide treatment to students injured while participating in such activities, whether or not such physicians or other health care professionals are paid for their services or volunteer their time to the School; or any other EMT, hospital, physician or other health care professional who evaluates, diagnoses or treats an injury or other condition incurred by the student while participating in school sponsored activities.

I understand that the School has requested this authorization to release or disclose the personal health information described above to make certain decisions about the Student's health and ability to participate in certain school sponsored and classroom activities, and that the School is a not a health care provider or health plan covered by federal HIPAA privacy regulations, and the information described below may be redisclosed and may not continue to be protected by the federal HIPAA privacy regulations. I also understand that the School is covered under the federal regulations that govern the privacy of educational records, and that the personal health information disclosed under this authorization may be protected by those regulations.

I also understand that health care providers and health plans may not condition the provision of treatment or payment on the signing of this authorization; however, the Student's participation in certain school sponsored activities may be conditioned on the signing of this authorization.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by a health care provider in reliance on this authorization, by sending a written revocation to the school principal (or designee) whose name and address appears below.

Name of Principal: _____

School Address: _____

This authorization will expire when the student is no longer enrolled as a student at the school.

NOTE: IF THE STUDENT IS UNDER 18 YEARS OF AGE, THIS AUTHORIZATION MUST BE SIGNED BY A PARENT OR LEGAL GUARDIAN TO BE VALID. IF THE STUDENT IS 18 YEARS OF AGE OR OVER, THE STUDENT MUST SIGN THIS AUTHORIZATION PERSONALLY.

_____

Student's Signature Birth date of Student, including year

_____

Name of Student's personal representative, if applicable

I am the Student's (check one): _____ Parent _____ Legal Guardian (documentation must be provided)

_____

Signature of Student's personal representative, if applicable Date

A copy of this signed form has been provided to the student or his/her personal representative

2012-2013 Ohio High School Athletic Association Eligibility and Authorization Statement

This document is to be signed by the participant from an OHSAA member school and by the participant's parent.

- I have read, understand and acknowledge receipt of the OHSAA brochure entitled "Your Athletic Eligibility," which contains a summary of the eligibility rules of the Ohio High School Athletic Association. I understand that a copy of the *OHSAA Handbook* is on file with the principal and athletic administrator and that I may review it, in its entirety, if I so choose. All OHSAA bylaws and regulations from the *Handbook* are also posted on the OHSAA web site at www.ohsaa.org.
- I understand that an OHSAA member school must adhere to all rules and regulations that pertain to the interscholastic athletics programs that the school sponsors, but that local rules may be more stringent than OHSAA rules.
- I understand that participation in interscholastic athletics is a privilege not a right.

Student Code of Responsibility

- 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 understand that a student whose character or conduct violates the school's Athletic Code or School Code of Responsibility is not in good standing and is ineligible for a period of time as determined by the principal

Informed Consent – By its nature, participation in interscholastic athletics includes risk of 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 have a responsibility to help reduce that 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 AN OHSAA-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, that 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.
- To enable the OHSAA to determine whether the herein named student is eligible to participate in interscholastic athletics in an OHSAA member school I consent to the release to the OHSAA any and all portions of school record files, 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.
- I consent to the OHSAA'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.
- 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 OHSAA academic standards and my eligibility.
- I understand all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly. Further I understand that if my student is removed from a competition due to a suspected concussion, he or she will be unable to return to competition that day without the written authorization from a physician (M.D. or D.O.) or an athletic trainer which indicates that the student has not been concussed..
- By signing this we acknowledge that we have read the above information and that we consent to the herein named student's participation.

***Must Be Signed Before Physical Examination**

Student's Signature _____ Birth date _____ Grade in School _____ Date _____

Parent's or Guardian's Signature _____ Date _____

Rev. 3/12

Self Medication Authorization

This form is to be used for the purpose of providing medication that a student athlete might need in a life threatening situation while at practice and/or game, meet, match, or contest. This would include, but not limited to, medication given in response to a bee sting for allergic students, a diabetic condition, or a breathing emergency, such as might occur with asthma. Any of these conditions can be a life threatening to a student athlete and the Monroe Local School District wishes to have the appropriate physician authorized medication to address these and other life threatening needs. Any other medication needed by a student in situations which are non life threatening can be given by the parent prior to the students practice or game or arrangements can be made for the nurse to administer the medication prior to the end of the school day. Please feel free to speak with the school nurse or trainer about any medical concerns regarding you son or daughter.

TO BE COMPLETED BY PHYSICIAN

Student Name:_____ DOB:_____ Grade:_____

Address:_____

Medication:_____ Dosage:_____

Adverse reactions to be reported to the physician:_____

_____

Adverse reactions for unauthorized user:_____

_____

Procedure to follow in the event that medication does not produce the expected relief from asthma attack:_____

_____

Other special instructions:_____

_____

This patient has been instructed in the proper use of this medication, the expected results and possible side effects and is capable of carrying and self administering this medication.

Physician Name:_____ Phone:_____

Physician Signature:_____ Date:_____

Parent/Guardian Signature:_____

Athlete Data

Please fill out the following questions as thoroughly as you can. Thank you.

Name: _____ _____
First Last

Student ID Number (Social Security Number) _____

Home Address: _____ _____ _____
Street City Zip

Date of Birth: _____ M or F Grade: _____

Sports: _____ Playing Positions: _____

Parent Name: _____ Other or Guardian: _____

Home Phone: _____ Home Phone: _____

Work Phone: _____ Work Phone: _____

Cell or Pager: _____ Cell or Pager: _____

Family Doctor: _____ Phone: _____

List any medication the athlete is currently taking: _____

List any trauma the athlete has suffered: _____

List any appliances the athlete wears (ex: braces, glasses, splints, etc...) _____

List any allergies: _____

List any orthopedic conditions such as sprains and strains: _____

List any surgeries: _____

List any broken bones or fractures: _____

List any illnesses: _____

Comments: _____

MONROE JUNIOR/SENIOR HIGH SCHOOL

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

ATHLETE INFORMATION

Sport(s) _____

Athlete's Given Name _____ Class of _____

Date of Birth (DOB) _____ Social Security Number (SSN) _____

I/we, the undersigned, hereby authorize the athletic trainer to release information that relates to the ability of the above named athlete to participate in athletics, as a result of an injury or illness, to the coaches, athletic director and parent/guardian. This information is released at the request of the athlete. Unless otherwise revoked this authorization expires upon graduation.

I understand that I may revoke this authorization in writing at any time, except if the athletic trainer has already released the information based on this authorization.

I understand that I am not required to sign this authorization form and that the athletic trainer will not condition the provision of treatment on the signing of this authorization.

X _____ Date _____
(athlete's signature)

X _____ Date _____
(parent/guardian's signature)

ANY REDISCLOSURE OF MEDICAL INFORMATION BY THE RECIPIENT IS PROHIBITED. I understand that if the person or entity that receives the above information is not a health care provider of health plan covered by federal privacy regulations, the information described above may be re-disclosed by such persons or entity and will likely no longer be protected by the federal privacy regulations.

REFUSAL OF RELEASE OF INFORMATION

Do not complete if you signed above

I/we, the undersigned, hereby **DO NOT** authorize the athletic trainer to release any information regarding any injury or illness, which occurs to the above named athlete, to the coaches or athletic director.

X _____ Date _____
(athlete's signature)

X _____ Date _____
(parent/guardian's signature)

A photocopy of this authorization is to be accepted the same as the original.

MONROE JUNIOR/SENIOR HIGH SCHOOL

ATHLETIC TRAINING MEDICAL INFORMATION

If authorization and consent for medical treatment is not completed, no treatment will be given to the athlete. Please make sure to fill out both sides of this form.

ATHLETE INFORMATION

Sport(s) _____ Class of _____

Athlete's Given Name _____

Date of Birth _____ Age _____ Sex M/F (Circle One)

Social Security Number _____ Home Phone _____

Medical Conditions _____

Allergies _____

PARENT/GUARDIAN CONTACT INFORMATION (SSN & DOB are optional entries)

Father's Name _____ Mother's Name _____

Daytime Ph # _____ Daytime Ph # _____

Cell Ph # _____ Cell Ph # _____

SSN _____ SSN _____

DOB _____ DOB _____

EMERGENCY CONTACT

Name _____ Work Phone _____

Relation _____ Home Phone _____

Primary Care Physician _____ Phone Number _____

AUTHORIZATION AND CONSENT FOR MEDICAL TREATMENT

I/we, the undersigned, in the event of an illness or athletic injury, hereby voluntarily consent to and authorize the evaluation and treatment considered necessary in the judgment of the athletic trainer or their designatee. Every attempt shall be made to contact me at the above numbers if an emergency arises.

X _____ Date _____
(athlete's signature)

X _____ Date _____
(parent/guardian's signature)

I/we, the undersigned, in the event of an illness or athletic injury, **DO NOT** hereby voluntarily consent to and authorize the evaluation and treatment considered necessary in the judgment of the athletic trainer or their designatee. Every attempt shall be made to contact me at the above numbers if an emergency arises.

X _____ Date _____
(athlete's signature)

X _____ Date _____
(parent/guardian's signature)

A photocopy of this document is to be accepted the same as the original.