# WALLACE JR/SR. HIGH SCHOOL

## ATHLETIC/ACTIVITY PARTICIPATION HANDBOOK

# RED BOOK

**Name: ______________________________________**

**(Please print full name)**

**Grade Level: ________________________ School Year: ______________**

# ***Player Information Form***

Student Name: _________________________ Parent(s) Name: ___________________________

Students Age: ______________ Birth Date: _________________ Year in School: __________

Home Address: ________________________ Mailing Address: ______________________

________________________ ______________________

Primary Phone: ________________________ Secondary Phone: ____________________

**This portion needs to be filled out completely. If it is not filled out your child cannot participate in athletics.**

School Insurance Needed: Yes ____________ No ______________
*insurance is required ***(you may contact the school for more information about sports insurance)***

Name of Insurance Company: __________________________________________

Insurance Card Number: ________________________________________

| | Yes | No |
|---|---|---|
| Any known allergic reaction to medications: | ______ | ______ |
| Had Surgery | ______ | ______ |
| Been Hospitalized | ______ | ______ |
| Been under a physician's care | ______ | ______ |
| Had a serious injury | ______ | ______ |
| Had an injury requiring a physician's care | ______ | ______ |
| Been rendered unconscious | ______ | ______ |
| Started taking any new medications | ______ | ______ |
| Developed any health problems | ______ | ______ |

(Please explain all yes answers):

Consent Form

I hereby consent to the above named student participation in the interscholastic athletic programs at Wallace Jr/Sr. High School. This consent includes travel to and from athletic contests and practice sessions. I further consent to treatment deemed necessary by physicians designated by school authorities for any illness or injury resulting from his/her athletic participation.

Signature of Parent/Guardian: _______________________________ Date: ___________________________

The Wallace School District aims to create a safe and secure environment for all students, including student-athletes. Given the responsibility of student-athletes driving to practice, it is important to have a comprehensive policy that outlines the guidelines and expectations for such activity. In addition, the Wallace School District will not hold liability for any accidents, damages, or injuries incurred as a result of students driving to practice.

Policy for Student Athletes Driving to Practice:

1. Student Eligibility: Only students who possess a valid driver's license and have adequate car insurance coverage (as per state requirements) will be allowed to drive themselves to athletic practices.

2. Safety Guidelines: Student athletes are required to adhere to all vehicular safety guidelines, including wearing seat belts, following speed limits, and abiding by traffic regulations.

3. Prohibited Activities: Student-athletes are strictly forbidden from engaging in risky driving behaviors, such as texting while driving, driving under the influence of drugs or alcohol, or driving recklessly. Violations of these rules will result in disciplinary action.

4. Reporting Accidents: In the event of an accident occurring en route to practice, student-athletes must immediately inform their coach and parents, and follow appropriate procedures for addressing the accident.

Release of Liability:

While student-athletes are encouraged to follow all safety measures and requirements outlined in this policy, the Wallace School District does not assume liability for any accidents, injuries, or damages that may occur as a result of students driving to practice or participating in carpooling arrangements. By granting permission for student-athletes to drive themselves to practice, parents and guardians acknowledge and accept this release of liability.

Parent Signature ________________________________ Date____________________

Athlete Signature ________________________________ Date_____________________

# HEALTH EXAMINATION *and* CONSENT FORM

It is required all students complete a history and physical examination prior to his/her first 9th and 11th grade practice in the interscholastic (9-12) athletic program in the State of Idaho. The exam is at the expense of the student and may not be taken prior to May 1 of the 8th and 10th grade years. This examination is to be done by a licensed physician, physician's assistant or nurse practitioner under optimal conditions. Interim history forms are required during the 10th and 12th grade years and must be submitted to the school administration prior to the first practice.

Name: ______________________ Sex: M / F Date of birth: ____________ Age: ________

Address: ______________________ Phone: ______________________

School: ______________________ Sports: ________________ Participation Grade: ________

## MEDICAL HISTORY

Fill in details of "YES" answers in space below:

| | Yes | No |
|---|---|---|
| 1. Have you ever been hospitalized? | ☐ | ☐ |
| Have you ever had surgery? | ☐ | ☐ |
| 2. Are you presently taking any medication or pills? | ☐ | ☐ |
| 3. Do you have any allergies (medicine, bees, other insects)? | ☐ | ☐ |
| 4. Have you ever passed out during or after exercise? | ☐ | ☐ |
| Have you ever been dizzy during or after exercise? | ☐ | ☐ |
| Have you ever had chest pain during or after exercise? | ☐ | ☐ |
| Do you tire more quickly than your friends during exercise? | ☐ | ☐ |
| Have you ever had high blood pressure? | ☐ | ☐ |
| Have you been told you have a heart murmur? | ☐ | ☐ |
| Have you ever had racing of your heart or skipped heartbeats? | ☐ | ☐ |
| Has anyone in your family died of heart problems or a sudden death before age 50? | ☐ | ☐ |
| 5. Do you have any skin problems (itching, rash, acne)? | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| 6. Have you ever had a head injury? | ☐ | ☐ |
| Have you ever been knocked out or unconscious? | ☐ | ☐ |
| Have you ever been diagnosed with a concussion? | ☐ | ☐ |
| Have you ever had a seizure? | ☐ | ☐ |
| Have you ever had a stinger, burned or pinched nerve? | ☐ | ☐ |
| 7. Have you ever had heat or muscle cramps? | ☐ | ☐ |
| Have you ever been dizzy or passed out in the heat? | ☐ | ☐ |
| 8. Do you have trouble breathing or do you cough during or after exercise? | ☐ | ☐ |
| 9. Do you use special equipment (pads, braces, neck rolls, mouth guard or eye guards, etc.)? | ☐ | ☐ |
| 10. Have you ever had problems with your eyes or vision? | ☐ | ☐ |
| Do you wear glasses, contacts or protective eyewear? | ☐ | ☐ |
| 11. Have you had any other medical problems ( infectious mononucleosis, diabetes, ect.)? | ☐ | ☐ |

**12. Have you had a medical problem or injury since your last evaluation?** ☐ Yes ☐ No

13. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any of bones or joints?

☐ head ☐ back ☐ shoulder ☐ forearm ☐ hand ☐ hip ☐ knee ☐ ankle

☐ neck ☐ chest ☐ elbow ☐ wrist ☐ finger ☐ thigh ☐ shin ☐ foot

14. Were you born without a kidney, testicle, or any other organ? ☐ Yes ☐ No

15. When was your first menstrual period? ______________________

When was your last menstrual period? ______________________

What was the longest time between your periods last year? ______________________

Explain "YES" answers: ______________________________________________

## CONSENT FORM

(Parent or guardian and student permission and approval)

I herby consent to the above named student participating in the interscholastic athletic program at his/her school of attendance. This consent includes travel to and from athletic contests and practice sessions. I further consent to treatment deemed necessary by physicians designated school authorities for any illness or injury resulting from his/her athletic participation. I also consent to release of any information contained in this form to carry out treatment and healthcare operations for the above named student.

If the health care provider's exam will be performed without compensation as part of the school's health examination program for participation in high school activities, I agree to the waiver provisions as set forth in Idaho Code Section 39-7703 and agree that the health care provider shall be immune from liability as specified in said section.

PARENT OR GUARDIAN SIGNATURE ______________________________ DATE: ____________

This application to compete in interscholastic athletics for the above school is entirely voluntary on my part and is made with the understanding that I have not violated any of the eligibility rules and regulation of the State Association.

SIGNATURE OF STUDENT ______________________________ DATE: ____________

# Idaho High School Activities Association

# Physical Examination Form

**Name:** ______________________________ **Date of Birth:** ___________

| **Height** _________ **Weight** __________ **BP** _____ / _____ **Pulse** _______ | | |
|---|---|---|
| **Vision R 20 / ____ L 20 / ____ Corrected: Y N** | | |
| | **Normal** | **Abnormal findings** |
| **Medical** | | |
| Pulses | | |
| Heart | | |
| Lungs | | |
| Skin | | |
| Ears, nose, throat | | |
| Pupils | | |
| Abdomen | | |
| Genitalia (males) | | |
| **Musculoskeletal** | | |
| Neck | | |
| Shoulder | | |
| Elbow | | |
| Wrist | | |
| Hand | | |
| Back | | |
| Knee | | |
| Ankle | | |
| Foot | | |
| Other | | |

## CLEARANCE / RECOMMENDATIONS

Clearance:

A. Cleared for all sports and other school-sponsored activates.

B. Cleared after completing evaluation/rehabilitation for:

______________________________________________________________

C. NOT cleared to participate in the following IHSAA sponsored sports /activities:

baseball basketball cheer/dance cross country football golf

soccer softball swimming tennis track volleyball wrestling

NOT cleared for other school-sponsored activities *(example: lacrosse)*:

______________________________________________________________

D. Student is NOT permitted to participate in high school athletics.

Reason: ______________________________________________

Recommendation:

Name of physician:

Address: ____________________________________________ Phone: __________________

Signature of physician/medical provider: __________________________________ Date: __________

(This *Physical Examination Form* MUST be signed by a licensed physician, physician assistant or nurse practitioner)