

# 2025-2026 Athletic Registration

This form is also available online through our school website

**Athletes: ALL 4 PAGES** must be signed and returned to the office before a student is allowed to participate in these Pillager activities. You may also pick up the complete MSHSL Athletic Brochure from the office or print it from [www.mshsl.org](http://www.mshsl.org)

On occasion, the JMC messaging system may be used to communicate schedule changes or information about your team. The numbers and emails in the school database will be used for this communication.

Participant's Name			Grade
Registering for			
Parent/Guardian Name (s)		Best contact phone # 1	
Student's cell phone #		Best contact phone # 2	
Emergency Name (if we can't get ahold of a parent)		Emergency best phone #	
<b>Allergies and health concerns.</b> (Please fill out as accurately as possible.)			
If emergency treatment is required and the parents can not be reached immediately, may the head coaching staff use their own judgment for medical treatment and/or transport.	<input type="checkbox"/> yes <input type="checkbox"/> no		If no, what do parents want done?
Parent/Guardian signature			Date signed

## Student Physical:

Physicals are good for three years. Forms are available if this student needs a physical. If you are not sure please contact Nicole Bramer at [nbramer@isd116.org](mailto:nbramer@isd116.org)

<b>Needed forms for Athletes:</b>	
	This "Athletic Registration" form
	2025-26 MSHSL Eligibility Statement
	MSHSL Annual Sports Health Questionnaire
	Big Stone Therapies, Inc.
Needed every THREE years	
	Sports Physical

Fees:

- \$60 Jr. High (grades 7-8)
- \$110 Jr. High Coop (grades 7-8)
- \$85 JV / Varsity (grades 9-12)
- \$135 JV/Varsity Coop (gr 9-12)
- \$350 Family Max

For office use only:

Paid Date: \_\_\_\_\_

Check # \_\_\_\_\_

Cash Received \_\_\_\_\_



## MSHSL Eligibility Brochure

This brochure is for your reference. If there is a question about any rule interpretation, **contact your school activities director or principal.**

**Students:** Your participation in MSHSL programs is dependent on your eligibility. Protect that eligibility by reviewing with your parent(s)/guardian(s) this summary of Minnesota State High School League rules which govern your participation. Complete policies and bylaws are found in the MSHSL Official Handbook, which is available at each member school and is available online at: [www.mshsl.org/governance](http://www.mshsl.org/governance).

I understand I must sign the current eligibility statement prior to participation each school year.

I understand that once I sign the eligibility statement all eligibility rules apply:

- Twelve months of the year;
- Whether I am currently participating or not;
- Continuously from the first signing of the statement through the completion of my high school eligibility.

**Parents/Guardians:** It is essential to review the following expectations.

### General Student Eligibility Checklist (must be completed by all students)

*(If you cannot check all 8 items, see your activities director or principal)*

- 1. I am making academic progress towards graduation.
- 2. I will not turn 20 before the start of the season in which I participate.
- 3. I have not dropped out of school or repeated a grade beginning with the initial entrance in the 9<sup>th</sup> grade.
- 4. I have not and will not use or possess tobacco or alcoholic beverages, use, consume, have in possession, buy, sell or give away any other controlled substance, including steroids, drug paraphernalia or products containing or used to deliver nicotine, tobacco products and other chemicals.
- 5. I have not and will not violate the racial/religious/sexual harassment/violence and hazing bylaws of the MSHSL.
- 6. I agree to fully cooperate in any investigation honestly and truthfully.
- 7. I agree to follow all of the MSHSL policies and bylaws in order to be eligible to represent my school in MSHSL programs, regardless of my age.
- 8. I have reviewed the concussion management information contained in the Eligibility Brochure and found on the following website: [www.cdc.gov/headsup](http://www.cdc.gov/headsup) with my parent(s)/guardian(s).

### Athletic Eligibility Checklist (must be completed by all athletes)

*(If you cannot check all 5 items, see your activities director or principal)*

- 1. I have a physical exam on file with the school, within the last three year.
- 2. I have not transferred schools.
- 3. I will not participate in more than six seasons in any sport in grades 7-12.
- 4. I have not accepted cash in any amount or merchandise valued at more than \$100 for participating in a sport.
- 5. I have not and will not compete in non-MSHSL events in my sport during my high school season.

**INFORMED CONSENT:** By its nature, participation in interscholastic athletics includes risk of injury and the transmission of infectious diseases such as HIV, Hepatitis B, Herpes and others. 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 the 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.



# 2025-2026 MINNESOTA STATE HIGH SCHOOL LEAGUE

## ANNUAL SPORTS HEALTH QUESTIONNAIRE

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Today's Date \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_

Date of Last Sports Qualifying Physical Exam (SQPE) \_\_\_\_\_ Sport(s) \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

**Check** Yes or No boxes for each question or **Circle** question numbers for which you cannot answer.

**IN THE LAST YEAR, since your last complete Sports Qualifying Physical Exam with your physician or your Year 2 Annual Health Questionnaire, HAVE YOU HAD ANY CHANGES TO THE FOLLOWING QUESTIONS:**

Athlete Health Questionnaire

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 1. In the last year, has a doctor restricted your participation in sports for any reason without clearing you to return to sports? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>IMPORTANT HEART HEALTH QUESTIONS ABOUT YOU IN THE LAST YEAR</b>  |                          |                          |
| 2. In the last year, have you passed out or nearly passed out during or after exercise? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. In the last year, have you had discomfort, pain, tightness, or pressure in your chest during exercise? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. In the last year, does your heart race or skip beats (irregular beats) during exercise? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. In the last year, do you get light-headed or feel more short of breath than expected during exercise? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. In the last year, have you had an unexplained seizure? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. In the last year, has a doctor told you that you have any heart problems? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. In the last year, has a doctor requested a test for your heart? For example, electrocardiography (ECG) or echocardiogram (ECHO)? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>IMPORTANT HEART HEALTH QUESTIONS ABOUT YOUR FAMILY IN THE LAST YEAR</b>  |                          |                          |
| 9. In the last year, has anyone in your immediate family died suddenly and unexpectedly for no apparent reason? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. In the last year, has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 (including an unexplained drowning or an unexplained car accident)? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. In the last year, has anyone in your immediate family had instances of unexplained fainting, seizures, or near drowning? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. In the last year, has anyone in your immediate family been diagnosed with hypertrophic cardiomyopathy, Marfan Syndrome, arrhythmogenic right ventricular cardiomyopathy, long or short QT Syndrome, Brugada Syndrome, or catecholaminergic polymorphic ventricular tachycardia? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. In the last year, has anyone in your immediate family under age 35 had a heart problem, pacemaker, or implanted defibrillator? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>MEDICAL RISK QUESTIONS IN THE LAST YEAR</b>  |                          |                          |
| 14. In the last year, have you had a head injury or concussion that still has symptoms like continuing headaches, concentration problems or memory problems? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. In the last year have you become ill while exercising in the heat? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. In the last year, have you learned that someone in your family has sickle cell trait or disease? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. In the last year, have you had numbness, tingling, weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling? .....  | <input type="checkbox"/> | <input type="checkbox"/> |

**Parents or Legal Guardians: Please note below any health concerns, medications, or allergies that may be important for the coaches or athletic/activities director to know.**

\_\_\_\_\_

I do not know of any existing physical or additional health reason that would preclude participation in sports. I certify that the answers to the above questions are true and accurate, and I approve participation in athletic activities.

Parent or Legal Guardian Signature \_\_\_\_\_ Athlete Signature \_\_\_\_\_ Date \_\_\_\_\_

**Activities Director Note: (a YES answer to any of the questions above requires a clearance note from a physician prior to participation.)**

\_\_\_\_\_

SQPE Due \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ **MEDICALLY ELIGIBLE FOR SPORTS PARTICIPATION: YES  NO**

Supplemental Mental Health Screening Questions (may be cut from form before submitting)

Over the past 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	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

(If the sum of responses to questions 1 & 2 or 3 & 4 are ≥3, please see your provider)



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

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

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

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

I may revoke this authorization at any time by notifying the above named school's Athletic Director in writing.

My letter must be hand delivered or mailed to the School.

A revocation will not affect any uses or disclosures that the above named school made before it received my revocation.

If I request it, I may see a copy of the health information described on this form.

The information that is used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA. I have the right to seek assurances from the above named entities or individuals authorized to receive the information that they will not re-disclose the information to any other party without my further authorization.

### Does your child have or carry with them: (Circle all that apply)

Asthma Inhaler

Epi-Pen

Diabetes (High or Low blood sugar, please indicate: \_\_\_\_\_). Do they carry insulin or glucose with them at all times:

Yes / No

Other: \_\_\_\_\_

## Consent for ImPACT and Release of Information

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

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

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

\_\_\_\_\_  
Print Student-Athlete's Name

\_\_\_\_\_  
Signature of Student-Athlete's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Parent/Guardian Name

\_\_\_\_\_  
Signature Parent/Guardian Name

\_\_\_\_\_  
Date