Appleton Area School District Required Athletic Forms/Consent

The completion of this form is required before a student may try out or participate in any athletic practice and/or competition.

No student may try out or participate in any athletic practice and/or competition until they have a current physical or alternate year on file. If you are unsure whether your student needs a physical or an alternative year physical, please contact your school.

Student Name: _____ **DOB:** _____

School Name: _____ **Grade:** _____

Concussion and Cardiac Arrest Information – see document here

By clicking on and reviewing the above link regarding concussions and sudden cardiac arrest, we agree that the student must be removed from practice/play if a concussion is suspected. We understand that it is our responsibility to seek medical treatment if a suspected concussion is reported. We understand that our student cannot return to practice/play until providing written clearance from an appropriate health care provider to his/her coach/advisor. We understand the possible consequences of our student returning to practice/play too soon. Sudden cardiac arrest is the leading cause of death in young athletes while training or participating in sport competition. We understand that athletes who appear healthy and have a normal participation screening may have underlying heart abnormalities that can be life threatening. We hereby acknowledge having received education about the signs, symptoms, and risks of sport related concussion and sudden cardiac arrest.

I certify by clicking Yes that I have read, understand, and agree to abide by all of the information contained in the sheet.

Yes No

AASD Co-Curricular Code of Conduct – see document here (High School) (Middle School)

We (parent/guardian and student) have read and understand the AASD Co-Curricular Code of Conduct and agree to abide by all of the information contained therein. We (parent/guardian and student) further certify that if we (parent/guardian and student) do not understand any information contained in the document, have sought out and received an explanation of the information prior to agreeing to the following: We understand that the student's participation in co-curricular activities is a privilege and, therefore, agree to be bound by the Appleton Area School District Co-Curricular Policy. We agree to participate in the suspicion-less random drug testing and give permission for testing and the release to the district concerning the results of said testing in the event the student is randomly selected. We understand this agreement is binding through graduation from high school.

Yes No

WIAA High School Athletic Eligibility Information Bulletin – see document here

We (parent/guardian and student) have read and understand the WIAA High School Athletic Eligibility Information Bulletin and agree to abide by all the information contained therein. We (parent/guardian and student) further certify that if we (parent/guardian and student) do not understand any information contained in the document, have sought out and received an explanation of the information.

Yes No

Liability Waiver

1. I hereby give my permission for my student to practice and compete and represent the school in WIAA approved interscholastic sports except those restricted on this form.

2. Pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder (collectively known as "HIPPA"), I authorize health care providers of the student named on this form, including emergency medical personnel and other similarly trained professionals that may be attending an interscholastic event or practice, to disclose/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.

3. I also attest to the fact that the student named on this form has had no injury or illness serious enough to warrant a medical evaluation prior to participating this school year.

I, person completing this form, have adequate insurance and am willing to take full financial responsibility for any and all injuries sustained by my son/daughter while participating, whether it be in a practice session or in actual competition, in a WIAA or any other sponsored sport in the Appleton Area School District Athletic program.

I further knowingly and voluntarily waive any and all claims against and forever release the Appleton Area School District, its Board Members, Officers, Agents, Employees and Volunteers for any and all injuries sustained by my son/daughter with participating, whether it be in a practice session or in actual competition, in a WIAA or any other sponsored sport in the Appleton Area School District Athletic program.

Yes No

Physical Form or Alternate Year

Date of last physical supplied to district: _____
(If this field is blank, the district does not have a physical date on file and **one will need to be submitted**.)

Current physical valid until: _____

If the student will be participating in athletics, a physical may be required. If your student had a physical last year, and it is remains valid, they do not need a physical again this year. Instead you will need to complete the alternate year information.

**Please note that a physical taken after April 1 is good for the next two years with this alternate waiver. Physicals taken before April 1 are good only for the remainder of that school year and during the following year with this alternate waiver. The school must still have a copy of the original physical on file, so new athletes or transfer students need to be prepared to supply the original physical.*

Please select the appropriate selection if your student will need a physical form or the alternate year information:

☐ **Alternate Year Information**

Please note that a physical taken after April 1 is good for the next two years with this alternate waiver. Physicals taken before April 1 are good only for the remainder of that school year and during the following year with this alternate waiver. The school must still have a copy of the original physical on file, so new athletes or transfer students need to be prepared to supply the original physical.

If there is any question that this student may not be healthy enough for athletic competition without, at least, a partial re-evaluation, contact your medical advisor before signing. Always defer to the recommendations of your primary care physician when deciding whether or not to have a new physical.

A new physical is required at least every two years by the WIAA in order to compete. Signing below indicates that my child is in good physical health and able to fully participate and has had a physical within the past two years which meets WIAA requirements.

Date of original physical: _____

☐ **Physical Form**

Physical Form Link (English) (Spanish) (Hmong)
If the student will be participating in athletics, please click on the link and print off the document to bring along to the doctor for the physical examination. The form needs to be filled out by both the student and the doctor, and returned to the school's athletic department before the student may practice or participate in an interscholastic athletic program.

Health Insurance
Insurance Company: _____
Policy/Group Number: _____

AASD Consent to Treat
I further grant permission for any medical records pertaining to the health of the name student athlete to be made available as necessary to the proper school

PERMISSION IS HEREBY GRANTED TO THE ATTENDING PHYSICIAN TO PROCEED WITH ANY MEDICAL TREATMENT. I UNDERSTAND THAT AN ATTEMPT WILL BE MADE BY THE ATTENDING PHYSICIA TO CONTACT ME IN THE MOST EXPEDITIOUS WAY POSSIBLE. PERMISSION IS ALSO GRANTED TO THE ATHLETIC TRAINER TO PROVIDE THE NEEDED EMERGENCY TREATMENT TO THE ATHLETE PRIOR TO HIS/HER ADMISSION TO THE MEDICAL FACILITIES.

Yes No

Administer First Aid
The athletic staff (athletic trainers, coaches, or other school personnel) may apply first aid treatment for any injury or injuries sustained during participation (practice/game) in interschool athletics until the parent/guardian can be contacted.

Yes No

Additional First Aid
In case the parents/guardians cannot be reached, we give consent for the athletic medical staff to use their own judgement in return to sport, securing medical aid, ambulance service, and if necessary, hospital admittance, when needed, as a result of injury during participation in sanctioned practices/games scheduled.

Yes No

Modalities First Aid
The athletic trainer may provide modalities such as, but not limited to, ultrasound, electrical stimulation, ice and heat.

Yes No

ThedaCare Consent to Treat

1. I am a parent or the court appointed legal guardian with medical decision-making authority for the Minor Patient (listed student), and authorized to make health care decisions on behalf of the Minor Patient.
2. I authorize ThedaCare providers (including healthcare profession students/residents) to provide the Minor Patient with emergency, urgent and routine medical care and treatment, including all diagnostic procedures.
3. I authorize ThedaCare to provide any Parent Substitute, if there is a delegation of parental power form on file for this child, with Protected Health Information relating to the Minor Patient. "Protected Health Information" means all medical records and treatment records relating to the Minor Patient which are protected and confidential under 42 C.F.R. Par 2, Wis. Stat. §§51.30 and 146.82, the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPPA"), and the Standards for Privacy of Individually Identifiable Health Information ("HIPPA Privacy Regulations"), 45 C.F.R. Part 160 and Part 164, subparts A and E.
4. This authorization is valid until revoked as described below, upon the Minor Patient reaching the age of majority or until _____. Parent or legal guardian is responsible to notify ThedaCare Orthopedics of any changes. This authorization may be changed or revoked at any time prior to that expiration date by providing ThedaCare with written notice. I am aware that any change or revocation will not be effective until after the date written notice is received.

I have carefully read, considered and agree with this consent before submitting.

In case of an emergency and neither parent/guardian can be reached, please contact the alternate listed below:

Alternate Name: _____

Alternate Phone: _____

Alternate Relationship: _____

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____