Hello and welcome to St Maries! Below you will find information necessary for participation in athletics at St. Maries Middle and High School. As a reminder, these documents are available to be signed and completed on Skyward for current St. Maries High School students.

Please review the following board policies online prior to signing the attached forms at https://smhs.sd41.org/athletics-activities/forms

Policy 3380 - Extracurricular and Co-curricular Participation Policy
Policy 3400 - Extracurricular Activities Drug Testing Program
Policy 0504.13 - Concussion Protocol

All students participating in sports at St Maries are required to have the following on file:

- Physical examination with a physician's signature, required for 9th and 11th graders and any new athlete
- Interim questionnaire 10th and 12th graders
- Athletic Assurances
- Emergency Contact Information/Enrolment form
- Signed Cocurricular Activities Code Policy 3380
- Signed Extracurricular Activities Drug Testing Consent form Policy 3400
- Signed Concussion Protocol Policy 0504.13
- Baseline ImPACT Test (Concussion test)
- Current ASB card and all fines paid or cleared prior to first competition
- Homeschooled students will need to submit transcripts and/or other documents to support their educational achievements

If you have any questions or need additional information please contact our Athletic Director, Dakota Wickard at dwickard@sd41.org

ST. MARIES JOINT SCHOOL DISTRICT NO. 41
2025-2026 Sports Season Medical Release/Emergency Contact

❑UpRiver School ❑St. Maries Middle School ❑St. Maries High School

Legal Name: _____ Grade: _____
Last First Middle
Preferred Name: _____ Primary Language Spoken in the Home: _____
(If different from above)

County of Residence:
❑Benewah ❑Shoshone
❑Kootenai ❑Other

Date of Birth: _____ Place of Birth: _____

❑Male ❑Female | Student's E-Mail Address: _____ | Student's Home Phone: _____ | Student's Cell Phone: _____ | Student resides with: _____

Mother's Name: _____ ❑Natural ❑Step

Address: _____ Home Phone: _____
City State Zip Cell: _____

Father's Name: _____ ❑Natural ❑Step

Address: _____ Primary Phone: _____
City State Zip

EMERGENCY INFORMATION

In the event a parent cannot be reached, please list below ***local*** relatives or friends the school office may contact to release your student to in case of illness, injury or school emergency:

First Emergency Contact: _____ Phone: _____

Relationship to Student: _____ Work Phone: _____

Second Emergency Contact: _____ Phone: _____

Relationship to Student: _____ Work Phone: _____

If my student becomes seriously injured or becomes ill at school or at a school activity and none of the emergency contact persons named above can be reached, I give my permission for school personnel to:

Transport my student to the local medical facility: ❑Yes ❑No

Call an ambulance and have my student transported to the nearest medical facility: ❑Yes ❑No

I give St. Maries Family Medicine and Benewah Community Hospital and their doctors and associates authorization to perform diagnostic evaluations, treat, administer drugs, and whatever else is deemed necessary to stabilize my student until I can be contacted. Should my student be brought to the Emergency Room, I hereby authorize any of the licensed medical staff to treat my student without further authorization. This authorization extends to all procedures, medical or surgical.

In the event that Dr. _____ cannot be reached, I specifically authorize any of the medical personnel at St. Maries Family Medicine and/or Benewah Community Hospital to select another physician to treat my student.

Parent/Guardian Signature: _____ Date: _____

MEDIA RELEASE

Throughout the year, the media, School District web page, and video productions may have need to present various aspects of the District's schools to the public through a variety of media which could include newsprint, the School District web page, Facebook, and videos produced by the district. As part of this media coverage, photographs and names of students are often requested to be published. Please check the appropriate box to indicate whether your student may participate in media coverage that may identify your student by photograph and/or name:

❑Yes, my student may participate in media coverage. ❑No, my student may not participate in media coverage.

Parent/Guardian Signature: Date:

St. Maries High School

Athletic Assurances

(2-Sided Form)

1. Health Insurance

I understand that my child cannot participate in high school athletics unless he or she is covered by health insurance. Please check one of the options below.

☐ I DO NOT wish to have my child enrolled in the school insurance plan because he or she is adequately covered by _____.

Name of Insurance Provider

☐ I DO wish to have my child enrolled in the school insurance plan because he or she is not covered. (Please provide a copy to the school)

2. ABSENCES & PARTICIPATION IN ACTIVITIES

A student who is absent during any part of the day and is scheduled to participate in an evening performance, function, athletic event or practice may not participate unless the absence is prearranged at least two days in advance.

3. STUDENTS SIGNING OUT OF AWAY GAMES

A student who is traveling on the bus to an away event must be signed out by a parent or legal guardian if they are not riding the bus home. The parent/legal guardian must be present at the time of sign-out. If legal parent/guardian wishes for another individual to sign their child out of an away game, they must complete the Alternate Transportation form at least two days prior to the event.

4. CO-CURRICULAR STUDENT ACTIVITY CODE

I understand that my performance as a participant and the reputation of my school are dependent, in part, on my conduct as an individual. I herby agree to accept and abide by the standards, rules, and regulations set forth by Joint School District No. 41 and the sponsors of the activity in which I participate. I have received and understand the Co-Curricular Activities Code.

This shall be deemed consent pursuant to the Family Education Right to Privacy Act for the release of the above information to the parties named above.

_____ Print Student Name

_____ Print Parent/Guardian Name

_____ Student Signature

_____ Parent/Guardian Signature

_____ Date

_____ Date

PLEASE TURN OVER AND COMPLETE OTHER SIDE

5. CONSENT FOR DISCLUSURE OF PROTECTED HEALTH INFORMATION

I, (as the parent or legal guardian) of _____, hereby authorize physicians, sports medicine staff, and other health care professionals representing Benewah Community Hospital to release information regarding my child's protected health information and any related information regarding any illness or injury during training for, and participation in school athletics. This protected health information may concern medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable health information. This protected health information may be released pursuant to this consent. This protected health information may be released to other healthcare providers, parents/guardians, hospital and/or medical clinic and laboratories, insurance carriers, and medical supply vendors.

I understand the protected health information is protected by federal regulations under the Health Insurance Portability and Accountability Act (HIPPA) and may not be disclosed without my authorization under HIPPA.

I understand that I may revoke this authorization/consent at any time by notifying in writing Benewah Community Hospital.

_____	_____	_____
Name of Student	Signature of Student	Date
_____	_____	_____
Date of Birth	Signature of Parent/Guardian	Date

6. RULES FOR PROPER USE OF HELMET (FOOTBALL ONLY)

The paragraph below is a statement to each player regarding the proper use of his/her helmet. This paragraph is stamped INSIDE each helmet and is required reading by each player. If after reading the paragraph below, you do not fully understand its content or have any questions, please see the head coach for clarification.

"DO NOT USE THIS HELMET TO BUTT, RAM, SPEAR AN OPPOSING PLAYER. THIS IS IN VIOLATION OF THE FOOTBALL RULES AND SUCH CAN RESULT IN SEVERE HEAD OR NECK INJURY, PARALYSIS, OR DEATH TO YOU AND POSSIBLE INJURY TO YOUR OPPONENT. NO HELMET CAN PREVENT ALL HEAD OR NECK INJURIES A PLAYER MIGHT RECEIVE WHILE PARTICIPATING IN FOOTBALL."

_____	_____
Print Student Name	Print Parent/Guardian Name
_____	_____
Student Signature	Parent/Guardian Signature
_____	_____
Date	Date

PLEASE TURN OVER AND COMPLETE OTHER SIDE

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)

INTERIM QUESTIONNAIRE

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:_____ Date of birth:_____ Sex: M / F

Address:_____ Phone:_____

School: _____ Participation Grade: _____

MEDICAL HISTORY

SINCE LAST PHYSCAL EXAMINATION, HAS THIS STUDENT:

Fill in details of "YES" answers in space below:	Yes	No
1. Had surgery?	☐	☐
2. Been hospitalized?	☐	☐
3. Been under a physician's care	☐	☐
4. Had serious illness?	☐	☐
5. Had an injury requiring a physician's care?	☐	☐
6. Been rendered unconscious?	☐	☐
7. Been diagnosed with a concussion?	☐	☐
8. Started taking any new medications?	☐	☐
9. Developed any new drug allergies?	☐	☐
10. Developed any health problems?	☐	☐

Explain "YES" answers:_____

_____

_____

_____

CONSENT FORM

(Parent or guardian and student permission and approval)

"I hereby 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 the student receiving health care services deemed necessary by health care providers or designated school authorities for any condition resulting from his/her athletic participation. I also consent to the release of any information contained in this form to carry out health care services including but not limited to screening, examination, and treatment for the above-named student. This meets the parental consent requirements set forth in Idaho Code Section 32-1015. 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 civil liability as specified in said section."

PARENT OR GUARDIAN SIGNATURE_____ DATE_____

This application to compete in interscholastic athletics for the above school in 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_____

Note: The original copy of this form MUST be returned to the school

ACKNOWLEDGEMENT OF RECEIPT OF CONCUSSION GUIDELINES

Parent's/Guardian's Signature

I, (print name) _____, acknowledge that I am the parent or guardian of the student named below, that I have received from the District information related to student athlete concussions, including information from the State Department of Education, the Idaho High School Activities Association, and District Policy 504.13, and have had the opportunity to review and have reviewed such information. I understand that participation in school athletic leagues or sports is dangerous, and hereby agree to waive all liability against St. Maries Joint School District No. 41, its employees, agents, and trustees, related to any injury or damages that my student may experience or incur as a result of participation in such school athletics leagues or sports.

_____ _____

Signature Date

Student's Signature

I, (print name) _____, acknowledge that I am a student of St. Maries Joint School District No. 41, or otherwise am allowed to participate in school athletic leagues or sports, that I have received from the District information related to student athlete concussions, including information from the State Department of Education, the Idaho High School Activities Association, and District Policy 504.13, and have had the opportunity to review and have reviewed such information. I understand that participation in school athletic leagues or sports is dangerous, and accept the risk of the potential consequences of such dangers.

_____ _____

Signature Date

NOTE: Both signature lines must be filled in and this form must be provided to the District prior to the student athlete participating in any school athletics leagues or sports.

ST. MARIES JOINT SCHOOL DISTRICT NO. 41
P. O. BOX 384
ST. MARIES, ID 83861

EXHIBIT "A"

STUDENT/PARENT/GUARDIAN
GOOD CONDUCT FORM

I understand that my performance as a participant and the reputation of my school are dependent, in part, on my conduct as an individual. I hereby agree to accept and abide by the standards, rules, and regulations set forth by St. Maries Joint School District No. 41 and the sponsors of the activity in which I participate.

This shall be deemed consent pursuant to the Family Education Right to Privacy Act for the release of the above information to the parties named above.

_____	_____
Student Signature	Parent or Guardian Signature
_____	_____
Print Name	Print Name
_____	_____
Date	Date

ST. MARIES JOINT SCHOOL DISTRICT NO. 41
P. O. BOX 384
ST. MARIES, ID 83861

EXHIBIT "A"

STUDENT/PARENT/GUARDIAN
DRUG TESTING CONSENT FORM

I understand that my performance as a participant and the reputation of my school are dependent, in part, on my conduct as an individual. I hereby agree to accept and abide by the standards, rules, and regulations set forth by St. Maries Joint School District No. 41 and the sponsors for the activity in which I participate.

I also authorize St. Maries Joint School District No. 41 to conduct tests on urine specimens, saliva samples, and/or breath, which I provide to test for drugs. I also authorize the release of information concerning the results of such a test to the Drug Testing Coordinator at St. Maries Joint School District No. 41, appropriate school personnel, and to my parents or guardians.

This shall be deemed consent pursuant to the Family Education Right to Privacy Act for the release of above information to the parties named above.

This Consent shall remain in effect for a period of one (1) calendar year from the date of parent and/or guardian signature.

_____	_____
Student Signature	Parent or Guardian Signature
_____	_____
Print Name	Print Name
_____	_____
Date	Date