FOR OFFICE USE ONLY	FOR OFFICE USE ONLY	FOR OFFICE USE ONLY
Fall: Amount _____ Date _____	**Winter:** Amount _____ Date _____	**Spring:** Amount _____ Date _____
Check _____ Cash _____	Check _____ Cash _____	Check _____ Cash _____.
Emergency Card In: _____	Emergency Card In: _____	Emergency Card In: _____

THIS FORM MUST BE COMPLETED, SIGNED AND RETURNED TO THE ACTIVITIES OFFICE ALONG WITH ALL FEES BEFORE THE STUDENT WILL BE PERMITTED TO PRACTICE

Student's Name _____ Age_____ Grade _____

Address _____ City _____ Zip _____

Phone ( ) _____ Date of Birth _____ M _____ F _____

Have you attended any other High School during grades 9 through 12? No _____ Yes _____ (If yes, see Activities Director)
List all the schools enrolled in during the following school years since entering 9th grade.

9th _____ 11th _____

10th _____ 12th _____

* Transfer students must complete the ***Transfer Student Information Form.*** (see Activities Director)
* Foreign Exchange students must complete the ***Foreign Exchange Student/International Student Registration Form.*** (see athletic office)

Parent/guardian _____ Cell/Home Phone _____ Work Phone _____

_____ Cell/Home Phone _____ Work Phone _____

Parent/Guardian email address_____

Non-parent emergency contact _____ Phone _____

Siblings participating in Athletics/Activites:_____

Athletic Fee: $210 per activity - Family Maximum: $700 Reduced lunch Fee: ($100) _____ Free lunch Fee:($50) _____

Fall: Cheerleading Cross Country Football PI Soccer Club Dance, Fall ($110)
Soccer Girls Swimming Girls Tennis Volleyball

Winter: Basketball Hockey Alpine Ski Nordic Ski
Boys Swimming Wrestling PI Fl Hockey Dance, Winter

Spring: Baseball Lacrosse Softball Boys Tennis
Golf PI Softball Track

Please read and complete ***both sides*** of this form – student and parent/guardian signatures are required. Your signatures indicate that you have read and agreed to the contents of this document. This form must be completed ***each year before*** the student will be allowed to practice or play. I /we understand that as a member school of the MSHSL all rules and regulations that pertain to the League athletic activities that a school may sponsor must be adhered to, but that local rules may be more stringent than MSHSL rule. (See district *Students Rights, Opportunities and Responsibilities and Discipline Guideline.).*

A sports physical exam record must be on file with the school prior to a student's participation. Physical exams are required every three years. The attached Health Questionnaire must be done every year. Athletes are not allowed to practice until the physical form/health questionnaire has been turned into the athletic office.

Office Only:
Date of last Sports Qualifying physical exam _____ (must be within three years) Health **Questionnaire** _____

Students must see the Bookkeeper to sign off on fees and fines. Overdue books and anything outstanding must be taken care of before the student is cleared to try-out.

Fees/Fines/Detentions	Fees/Fines/Detentions	Fees/Fines/Detentions
Fall: _____	**Winter:** _____	**Spring:** _____
_____	_____	_____

STUDENT CODE OF RESPONSIBILITIES

The member schools of the Minnesota State High School League believe that participation in interscholastic activities is a privilege which is accompanied by responsibility. As a student participating in my school's interscholastic activities, I understand and accept the following responsibilities.

- Students must be academically eligible to participate in all extracurricular activities.
- 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 understand I am responsible for the return or reimbursement of all equipment issued to me within one week of completion of the season. A monetary fee will be issued upon failure to do so.
- I understand that all personal items left in the athletic locker will be disposed of two weeks after the completion of the season.
- I will respect and obey the rules of my school and the 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 once I sign, all eligibility rules apply for twelve months of the year, weather I am currently participating or not and continuously from the first signing of the statement.
- Student who receives a violation in season will not receive an athletic letter/post season awards.
- Code of conduct/chemical violations could result in loss of captaincy for one calendar year.
- **A student whose character or conduct violates the Student Code of Responsibilities or is suspended or expelled is not in good standing and in ineligible for a period of time as determined by the principal. While a student is not in good standing, a student may not serve any penalty or MSHSL bylaw violations until they return as a full time student at Armstrong.**

Date _____ Student Signature _____

The parent's should read and sign below:

- Grants this student permission to participate in all Minnesota State High school League (MSHSL) activities.
- Grants permission for this student to go on all supervised trips connected with MSHSL activities.
- Indicates understanding that this student will refrain from practice or play, while under medical treatment and until he or she provides written physician permission to resume participation.
- Certifies that this student is physically fit to participate in all high school interscholastic activities.
- Read and agree to the Athletic Trainer Authorization
- Read and understand the Eligibility Guidelines for participants.

ATHLETIC/ACTIVITY INSURANCE WAIVER/INFORMED CONSENT

By its nature, participation in interscholastic athletics includes risk of injury and the transmission of infectious diseases 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 the 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. Participants are informed that mouth guards are mandatory in football and hockey. Mouth guards also are recommended in volleyball, basketball, soccer, wrestling, baseball and softball. The decision to wear or not to wear a mouth guard in these sports shall be left up to each family.

By signing this, we acknowledge that we have read the above information. PARENTS, GUARDIANS OR STUDENT WHO MAY NOT WISH TO ACCEPT THE RISK DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS FORM. STUDENTS MAY NOT PARCITIPATE IN A SCHOOL-SPONSORED ACTIVITY WITHOUT THE STUDENT'S AND PARENT'S/GUARDIAN'S SIGNATURE.

I HEREBY GIVE MY CONSENT FOR THE STUDENT NAMED ABOVE.

1. To represent Robbinsdale Area Schools in approved student activities except those indicated by an examining medical doctor.
2. To receive, through a medical doctor of the school's choice, emergency medical care which may become reasonably necessary in the course of activities or travel.
3. I fully understand the Robbinsdale Area Schools does not provide any accident or health insurance coverage for my boy/girl while participating in student activities. I fully understand that is it my responsibility to provide insurance coverage for my boy/girl. I further agree not to hold the school or anyone acting in its behalf responsible for any injury occurring to the student named above in the proper course of such student activities or travel. This includes use of school issued equipment.

ATHLETIC TRAINER AUTHORIZATION

Armstrong High School staffs a certified and registered athletic trainer through the Institute for Athletic Medicine for the purposes of educating student-athletes and preventing and treating injuries to the student-athletes while participating in school-related events and programs.

I consent to the athletic trainer treating injuries and discussing any injuries or medical conditions with coaches, school staff and other qualified health care providers as deemed necessary within their scope of practice.

I understand that in the case of injury or illness requiring transportation to a health care facility, every attempt will be made to contact me but that, if necessary, the student-athlete will be transported via ambulance to the nearest hospital.

A copy of Fairview's Notice of Privacy Practices can be obtained via internet at www.fairview.org, e-mail to privacyl@fairview.org, or mail to FairviewPrivacy Office 2450 Riverside Ave, Minneapolis, MN 55454.

Date _____ **Parent Signature** _____

MSHSL ANNUAL SPORTS HEALTH QUESTIONNAIRE

DATE _____ /_____ / _____

Name _____ **M/F** _____ **Age** ____ **Birth Date** _____ / _____ / _____

Grade ____ **School** _____ **Sport(s)** _____

Address _____

Phone _____ **Date of Last Sports Qualifying Physical Exam (SQPE)** _____ / _____ / _____

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:

		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?	☐	☐
	IMPORTANT HEART HEALTH QUESTIONS ABOUT YOU IN THE LAST YEAR		
2.	In the last year, have you passed out or nearly passed out *during* or *after* exercise?	☐	☐
3.	In the last year, have you had discomfort, pain, tightness, or pressure in your chest during exercise?	☐	☐
4.	In the last year, does your heart race or skip beats (irregular beats) during exercise?	☐	☐
5.	In the last year, do you get light-headed or feel more short of breath than expected during exercise?	☐	☐
6.	In the last year, have you had an unexplained seizure?	☐	☐
	IMPORTANT HEART HEALTH QUESTIONS ABOUT YOUR FAMILY IN THE LAST YEAR		
7.	In the last year, has anyone in your immediate family died suddenly and unexpectedly for no apparent reason?	☐	☐
8.	In the last year, has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including an unexplained drowning, an unexplained car accident, or Sudden Infant Death Syndrome)?	☐	☐
9.	In the last year, has anyone in your immediate family had instances of unexplained fainting, seizures, or near drowning?	☐	☐
10.	In the last year, has anyone in your immediate family developed hypertrophic cardiomyopathy, Marfan Syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT Syndrome, short QT Syndrome, Brugada Syndrome, or catecholaminergic polymorphic ventricular tachycardia?	☐	☐
11.	In the last year, has anyone in your immediate family been diagnosed with Marfan Syndrome, arrhythmogenic right ventricular cardiomyopathy, long or short QT Syndrome, Brugada Syndrome, or catecholaminergic polymorphic ventricular tachycardia?	☐	☐
12.	In the last year, has anyone in your immediate family under age 50 had a heart problem, pacemaker, or implanted defibrillator?	☐	☐
	MEDICAL RISK QUESTIONS IN THE LAST YEAR		
13.	Have you had infectious mononucleosis (mono) within the last month?	☐	☐
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?	☐	☐
15.	In the last year, have you had numbness, tingling, weakness in, or inability to move your arms or legs after being hit or falling?	☐	☐

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

Athletic/Activity Director Notes: (a YES answer to any of the questions above requires a clearance note from a physician prior to participation.)

_____

_____

_____

SQPE Due ____ / _____ /_____ **CLEARED FOR SPORTS: YES** ☐ **NO** ☐

Reference: Preparticipation Physical Evaluation (Third Edition): AAFP, AAP, AMSSM, AOSSM, AOASM ; McGraw-Hill, 2004.

Revised 4/17/15

CONCUSSION MANAGEMENT RECOMMENDATIONS FOR MSHSL ATHLETES

Acute injury
When a player shows any symptoms or signs of a concussion, the following should be applied.

1. The player should not be allowed to return to play in the current game or practice.
2. The player should not be left alone, and regular monitoring for deterioration is essential over the initial few hours after injury.
3. The player should be medically evaluated after the injury.
4. Return to play must follow a medically supervised stepwise process.

A player should never return to play while symptomatic. "When in doubt, sit them out!"

Return to play protocol

Return-to-play decisions are complex. An athlete may be cleared to return to competition only when the player is free of all signs and symptoms of a concussion at rest and during exercise. Once fee of symptoms and signs of concussion, a stepwise symptom free exercise process is required before a player can return to completion.

- Each step requires a minimum of 24 hours.
- The player can proceed to the next level only if he/she continues to be free of any symptoms and/or signs at the current level.
- If any symptoms or signs reoccur, the player should drop back to the previous level.

The return to play after a concussion follows a stepwise process:

1. No activity, complete rest until all symptoms have resolved. Once asymptomatic, proceed to level 2.
2. Light aerobic exercise such as walking or stationary cycling, no resistance training.
3. Sport specific exercise—for example, skating in hockey, running in soccer; progressive addition of resistance training at steps 3 or 4.
4. Non-contact training drills.
5. Full contact training after medical clearance.
6. Game play.

The final return to competition decision is based on clinical judgment and the athlete may return only with written permission from a health care provider who is registered, licensed, certified, or otherwise statutorily authorized by the state to provide medical treatment; is trained and experienced in evaluating and managing concussions; and is practicing within the person's medical training and scope of practice.

Neuropsychological testing or balance testing may help with the return to play decision and may be used after the player is symptom free, but the tests are not required for the symptom free player to return to play.

For more information please refer to the references listed below and www.concussionsafety.com.

Signs Observed By Coaching Staff	**Symptoms Reported By Athlete**
Appears dazed and stunned	Headache or "pressure" in head
Is confused about assignment or position	Nausea or vomiting
Forgets sports plays	Balance problems or dizziness
Is unsure of game, score, or opponent	Double or blurry vision
Moves clumsily	Sensitivity to light
Answers questions slowly	Sensitivity to noise
Loses consciousness (even briefly)	Feeling sluggish, hazy, foggy, or groggy
Shows behavior or personality changes	Concentration or memory problems
Can't recall events prior to hit or fall	Confusion
Can't recall events after hit or fall	Does not "feel right

Student's Printed Name *Birth Date* *Grade in School*

Student's Signature *Date*

Parent's or Guardian's Signature *Date*

ARMSTRONG ACTIVITY EMERGENCY CARD

Date: _____ **Activity** _____

Student Name: _____ **Grade:** _____

Address: _____ **Hm#** _____

Mother/Guardian: _____ **Cell:** _____

Father/Guardian: _____ **Cell:** _____

Non-Parent to notify in an emergency: _____

Phone Number(s): _____

Medical History: Answer Yes/No: Diabetes? _____ **Epilepsy?** _____ **Asthma?** _____

Allergies: _____ **If yes, please list:** _____

Any other medical concerns we should know about: _____

_____

Family Doctor _____ **Phone #** _____

Hospital _____ **Phone #** _____

Insurance Co _____ **Policy #** _____

Signature of Parent/Guardian: _____ **Date** _____