WEST VIRGINIA SECONDARY SCHOOL ACTIVITIES COMMISSION Revised 3-28

2875 Staunton Turnpike - Parkersburg, WV 26104

ATHLETIC PARTICIPATION/PARENTAL CONSENT/PHYSICIAN'S CERTIFICATE FORM

(Form required each school year on or after May 1". File in School Administration Office)

ATHLETIC PARTICIPATION/ PARENTAL CONSENT

PART I

Name _____ School Year: _____ Grade Entering: _____

Home Address: _____ Home Address of Parents: _____

City: _____ City: _____

Phone: _____ Date of Birth: _____ Place of Birth: _____

Last semester I attended _____(High School) or (Middle School). We have read the condensed eligibility rules of the WVSSAC athletics. If accepted as a team member, we agree to make every effort to keep up schoolwork and abide by the rules and regulations of the school authorities and the WVSSAC.

PART II - PARENTAL CONSENT

INDIVIDUAL ELIGIBILITY RULES

- Attention Athlete! To be eligible to represent your school in any interscholastic contest, you:
- Must be a regular bona fide student in good standing of the school. (See exception under Rule 127-2-3) must qualify under the Residence and Transfer Rule (127-2-7)
- Must have earned at least 2 units of credit the previous semester. Summer School may be included. (127-2-6)
- Must have attained an overall "C" (2.00) average the previous semester. Summer School may be included. (127-2-6) must not have reached your 15th (MS), 19th (HS) birthday before July 1 of the current school year. (127-2-4)
- Must be residing with parent(s) as specified by Rule 127-2-7 and 8.
unless parents have made a bona fide change of residence during school term. Unless an AFS or other Foreign-Exchange student (one year of eligibility only).
- Unless the residence requirement was met by the 365 calendar days attendance prior to participation. if living with legal guardian/custodian, may not participate at the varsity level. (127-2-8)
- Must be an amateur as defined by Rule 127-2-11.
- Must have submitted to your principal before becoming a member of any school athletic team Participation/Parent Consent/Physician Form, completely filled in and properly signed, attesting that you have been examined and found to be physically fit for athletic competition and that your parents' consent to your participation. (127-3-3)
- Must not have transferred from one school to another for athletic purposes. (127-2-7)
- Must not have received, in recognition of your ability as a HS or MS athlete, any award not presented or approved by your school or the WVSSAC. (127-3-5)
- Must not, while a member of a school team in any sport, become a member of any other organized team or as an individual participant in an unsanctioned meet or tournament in the same sport during the school sport season (See exception 127-2-10).
- Must follow All Star Participation Rule. (127-3-4)
- Must not have been enrolled in more than (14) semesters in grades 6 to 12.
- Eligibility to participate in interscholastic athletics is a privilege you earn by meeting not only the above listed minimum standards but also all other standards set by your school and the VI/VSSAC. If you have any questions regarding your eligibility or are in doubt about the effect any activity or action might have on your eligibility, check with your principal or athletic director. They are aware of the interpretation and intent of each rule. Meeting the intent and spirit of 'WVSSAC' standards will prevent athletes, teams, and schools from being penalized.

MEDICAL DISQUALIFICATION OF THE STUDENT-ATHLETE/ WITHHOLDING A STUDENT-ATHLETE FROM ACTIVITY

The member school's team physician has the final responsibility to determine when a student-athlete is removed or withheld from participation due to an injury, an illness or pregnancy. In addition, clearance for that individual to return to activity is solely the responsibility of the member school's team physician or that physician's designated representative.

I understand that participation may include, when necessary, early dismissal from classes and travel to participate in interscholastic athletic contests. I will not hold the school authorities or West Virginia Secondary School Activities Commission responsible in case of accident or injury as a result of this participation. I also understand that participation in any of those sports listed above may cause permanent disability or death. Please check appropriate space; He/She has student accident insurance available through the school ( ); has football insurance coverage available through the school ( ); is insured to our satisfaction ( ).

I also give my consent and approval for the above named student to receive a physical examination, as required in Part IV, Physician's Certificate, of this form, by an approved health care provider as recommended by the named student's school administration.

I consent to WVSSAC's use of the herein named student's name, likeness, and athletically related information in reports of Inter-School Practices or Scrimmages and Contests, promotional literature of the Association, and other materials and releases related to interscholastic athletics.

I have read/reviewed the concussion and Sudden Cardiac Arrest information as available through the school and at WVSSAC.org. (Click Sports Medicine)

Date: _____ Student Signature _____ Parent Signature _____

PART III - STUDENT'S MEDICAL HISTORY
(To be completed by parent or guardian prior to examination)

Name _____ Birthdate ___ /_____ Grade ___ Age ___

Has the student ever had:

Yes No 1. Chronic or recurrent illness? (Diabetes, Asthma, Seizures, etc.,)

Yes No 2. Any hospitalizations?
Yes No 3. Any surgery (except tonsils)?
Yes No 4. Any injuries that prohibited your participation in sports?
Yes No 5. Dizziness or frequent headaches?
Yes No 6. Knee, ankle or neck injuries?
Yes No 7. Broken bone or dislocation?
Yes No 8. Heat exhaustion/sun stroke?
Yes No 9. Fainting or passing out?
Yes No 10. Have any allergies?
Yes No 11. Concussion? If Yes _____
Date

PLEASE EXPLAIN ANY "YES" ANSWERS OR ANY OTHER ADDITIONAL CONCERNS.

Yes No 12. Have any problems with heart/blood pressure?
Yes No 13. Has anyone in your family ever fainted during exercise?
Yes No 14. Take any medicine?
List:

Yes No 15. Wear glasses _, contact lenses_, dental appliances_?
Yes No 16. Have any organs missing (eye, kidney, testicle, etc.)?
Yes No 17. Has it been longer than 10 years since your last tetanus shot?
Yes No 18. Have you ever been told not to participate in any sport?
Yes No 19. Do you know of any reason this student should not participate in sports?
Yes No 20. Have a sudden death history in your family?
Yes No 21. Have a family history of heart attack before age 50?
Yes No 22. Develop coughing, wheezing, or unusual shortness of breath when you exercise?
Yes No 23. (Females Only) Do you have any problems with your menstrual periods.

I also give my consent for the physician in attendance and the appropriate medical staff to give treatment at any athletic event for any injury.
SIGNATURE OF PARENT OR GUARDIAN _____ DATE ___/___/_____

PART IV-VITAL SIGNS

Height _____ Weight _____ Pulse _____ Blood Pressure _____ __
Visual acuity: Uncorrected_____/_____;Corrected_____/_____Pupils equal diameter: Y N

PART V - SCREENING PHYSICAL EXAM

This exam is not meant to replace a full physical examination done by your private physician.

Mouth:			Respiratory:			Abdomen:			
Appliances	Y	N	Symmetrical breath sounds	Y	N	Masses	Y	N	
Missing/loose teeth	Y	N	Wheezes	Y	N	Organomegaly	Y	N	
Caries needing treatment	Y	N	Cardiovascular:						
Enlarged lymph nodes	Y	N	Murmur	Y	N				
Skin - infectious lesions	Y	N	Irregularities	Y	N				
Peripheral pulses equal	Y	N	Murmur with Valsalva	Y	N				

Any "YES" under Cardiovascular requires a referral to family doctor or other appropriate healthcare provider.

Musculoskeletal: (note any abnormalities)

Neck:	Y	N	Elbow:	Y	N	Knee/Hip:	Y	N	Hamstrings:	Y	N
Shoulder:	Y	N	Wrist:	Y	N	Ankle:	Y	N	Scoliosis:	Y	N

Over the last 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

RECOMMENDATIONS BASED ON ABOVE EVALUATION:
After my evaluation, I give my:

___ Full Approval;
___ Full approval; but needs further evaluation by Family Dentist__ ; Eye Doctor__ ; Family Physician_ ; Other__ ;
___ Limited approval with the following restrictions: _____,
___ Denial of approval for the following reasons: _____ __

_____ _____
MD/DO/DC/Advanced Registered Nurse Practitioner/Physician's Assistant Date