Student's Name: _____
Activity: _____

Eligibility Checklist:

_____ 1. Physical exam within the last three years on file with the school. Not applicable to non-athletic activities.

_____ 2. 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.

_____ 3. Making academic progress (to remain eligible a student cannot be failing at any point during a grading period).

_____ 4. All fees and forms turned into Nathan Schwieters. Forms include:

Registration Form
Eligibility Statement
Emergency Information and Contact Form
School Medical Form
Physical Form or Physician Written Clearance
Code of Conduct Agreement
Fee

All forms and Fees (or Delayed Payment/Scholarship Form) MUST be turned in to Nathan Schwieters prior to participating in a practice or meeting.

Eligibility Penalties:

1. First Violation: Student shall lose eligibility in that sport/activity for the next two weeks. If there are fewer than two weeks remaining in that activity, the loss of eligibility will continue into the next activity.
2. Second Violation: The student will lose eligibility for the next four weeks.
3. Third Violation: The student will lose eligibility for the rest of that activity or six weeks which ever is greater.

Activity Policies Eligibility Statement

I have read, understand and acknowledge receiving the Activity Policies Brochure.

As a student participating in an activity at STRIDE Academy, I understand and accept the following responsibilities.

1. *I will respect the rights and beliefs of others and will treat others with courtesy and consideration.*
2. *I will be fully responsible for my actions and the consequences.*
3. *I will respect the property of others.*
4. *I will respect and obey the rules of my school and the laws of my community, state and country.*
5. *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.*

Informed Consent: By its nature, participation in athletics includes risk of injury and the transmission of infectious diseases such as HIV, Herpes and Hepatitis B and others. Although serious injuries are not common and the risk of HIV transmission is almost nonexistent in athletic programs, it is impossible to eliminate all risk. Participants must obey all rules, report all physical and hygiene problems to their coaches/advisors, follow proper conditioning program and inspect their own equipment. Do not sign this form if you are not comfortable with its terms.

I consent to the coach treating injuries and authorize them to discuss those injuries with and release any applicable medical information or records relating to those injuries to coaches, school staff and other qualified health care providers as deemed necessary within their scope of practice.

I further understand that in the case of injury or illness requiring transportation to a health care facility that a reasonable attempt will be made to contact the parent/guardian, but that, if necessary, the student-athlete will be transported via ambulance or quickest transport to the nearest hospital.

I understand and release any liability from injury during the transport in emergency situations and also to and from activity competitions.

Student's Signature Grade Date

Parent's or Guardian's Signature Date Phone Number

Emergency Information & Contact Form

In case of an emergency, our procedure will be to contact the parent at home or at work. When a parent cannot be reached, the designated person on this form will be contacted and if applicable an ambulance or police car will be called. You should make arrangements for proper care in case your child should become injured or ill during a practice or game.

This sheet will speed emergency care according to your wishes. This form will need to be filled out again if there are address or phone number changes during the sport season.

Emergency & Contact Information

Pupil _____ **Teacher** _____
Last First Middle

Home Address _____ **Phone** _____

_____ **Cell/Work** _____

Physician's Name _____ **Phone** _____

Dentist's Name _____ **Phone** _____

Person(s) who will care for my child in case parent cannot be reached

_____
Name **Address** **Phone**

_____
Name **Address** **Phone**

_____
Parent Signature **Date**

Annual Health Information
School Year: 2018-2019

Student Name: _____ **Birth Date:** _____
Last Middle First

Grade/Room: _____ **School Attended Last year (if applicable) :** _____

Dear Parent/Guardian:
Your child's health may affect his or her learning. Therefore, health information is important in planning for your child's needs at school. Health information from this form may be shared with other school staff as needed. Please complete this form and return it to school prior to attending.

_Michelle Hahn, RN, PHN____ 320-230-5340
Licensed School Nurse Phone

HEALTH CONCERNS

Please put an X if your child has any of these health concerns:

_____***No Health Concerns***
_____A.D.H.D./A.D.D.
_____Allergies (to what?) _____
_____Asthma or other breathing problems
a. Has your child ever been diagnosed by a **Doctor** as having asthma? **YES**_____ **NO**_____
b. Has your child had episode(s) of wheezing (whistling in the chest) in the last **12 months**? **YES**_____ **NO**_____
c. In the last **12 months** have you heard your child wheeze or cough after active playing?
d. Other breathing problem/s (describe) **YES**_____ **NO**_____
_____Diabetes
_____Heart Problems (describe) _____
___Activity restrictions _____
_____Seizures (describe)_____
_____Social/emotional/mental health (describe) _____
_____Bladder / Bowel concerns or modifications needed (describe) _____
_____Other health concern or significant history of problems (describe) _____
Any recent surgeries or hospitalization: NO_____ YES_____ (please describe)_____

EMERGENCIES: Does your child have a health problem that could result in an emergency? **YES**_____ **NO**_____
If yes, describe:

_____

MEDICATIONS: List **ALL** medications that your child takes every day or when needed. **A SCHOOL MEDICATION PERMISSION FORM is required to be completed and signed by both the parent and the prescribing Health Care Provider** for each and any medication needing to be administered during school hours, **including over the counter medications.** *A new consent is needed each school year.* Forms are available from the administrative office. (You may use the back of this form to continue list if necessary)

Medication Name ***Dose*** ***Purpose*** ***How often taken?***

_____

I give permission for the school nurse to contact my child's health care provider in reference to any of the above health concerns.

_____

Parent's Signature **Date**

HEALTH INSURANCE INFORMATION:

My child has health insurance: NO_____ YES_____ Type:_____

HEALTH CARE PROVIDERS:

Does your child have a doctor or clinic where they usually go for health care? YES_____ NO_____

Name Of Doctor or Clinic	Location and Phone	Approximate date of Last Exam

*Preferred Hospital in the event of EMS: _____

*** REQUIRED FOR SCHOOL ADMISSION ***

To Be Completed by the Primary Health Care Provider

Please have your child's physician complete and sign the following portion of this form:

Date of Physical Examination: _____

Indicate Normal (N) or Abnormal (AB) If Abnormal include comments below.

	N	AB		N	AB
Skin/Lymph			Heart		
Eyes			Lungs		
Ears			Abdomen		
Nose			Genito-Urinary		
Throat			Orthopedic-feet		
Neck			Orthopedic-spine		
			Neurological		

Comments:

VISION Date of Last Exam: _____

Exam Method:_____
No vision problem:_____
Vision Problems/History:_____
_____
_____

HEARING Date of Last Exam: _____

Exam Method:_____
No Hearing Problems:_____
Hearing Problems/History:_____
_____
_____

*** Please attach any additional health/medical history information which you feel pertinent to this student's health history.**

****

_____ _____ _____

Physicians' Name (Please Print) **Physician's Signature** **Date**

_____

Office/Clinic Location **Phone**