



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, whichever 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: 2019-2020

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.

Myra Schrup RN, PHN
Licensed School Nurse

320-230-5340
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)

Table with 4 columns: 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