

# Athletic Participation Fee Form

To: Parents and Athletes

From: Athletic Director

Date: \_\_\_\_\_

## Rationale

The payment of a participation fee is necessary for the Athletic Department to continue to offer this activity as a part of the athletic program. This fee must be paid by the first day of participation by the athlete so the budgetary obligations associated with this activity can be met.

## Guarantee

The payment of this fee does **not** guarantee the athlete game participation time. Playing time is at the coach's discretion. Athletes who quit or are dismissed for disciplinary reasons **will not** have the Participation Fee refunded.

## Fee

The fee for Soccer, Volleyball & Basketball is \$60 while the fee for Cheerleading and Track is \$40 per student of Heritage Christian School. Please make all checks payable to Heritage Christian School.

## Uniform Contract

The student athlete will be issued a school uniform at the beginning of the season. At the end of the season the student is responsible to return it, cleaned and in good repair. If a school issued uniform is lost or not returned, parents will be billed for the cost of replacing the uniform.

\_\_\_\_\_  
Athlete's Name

\_\_\_\_\_  
Sport

These forms must be turned in by the first day of practice:

\_\_\_ Fee

\_\_\_ Athletic Contract

\_\_\_ Insurance Waiver

\_\_\_ Emergency Medical Authorization

\_\_\_ Physical

\_\_\_ Concussion Form

# Heritage Christian School Athletic Contract

For Parents and Athletes

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In all aspects of life, followers of Jesus Christ are called to be excellent (1Corinthians 9:24-27), not as a means of garnering accolades for themselves but rather for the glory of God {Colossians 3:23}. We are called to humbly bring our best effort and seek excellence that focuses on "process" over "accomplishment" and this neatly applies to interscholastic athletics. Heritage Christian School strives to take advantage of every opportunity on the field and court to reinforce the pursuit of these goals through the athletic program:

## Goals:

1. Compete In a God-glorifying manner – *Colossians 3:16,17 - Let the word of Christ dwell in you richly, teaching and admonishing one another in all wisdom, singing psalms and hymns and spiritual songs, with thankfulness in your hearts to God. And whatever you do, in word or deed, do everything in the name of the lord Jesus, giving thanks to God the Father through Him.*
2. Develop Christ-like character in student athletes – *Titus 2:6-8 – Likewise, urge the younger men to be self-controlled. Show yourself in all respects to be a model of good works, and in your teaching show integrity, dignity, and sound speech that cannot be condemned, so that an opponent may be put to shame, having nothing evil to say about us.*
2. Develop and refine fundamentals skills
3. Establish positive relationships

## Contract Expectations:

1. I understand the goals established for the Athletic Program at Heritage Christian School and will commit whole-heartedly to the pursuit of stated goals.
2. I will conduct myself in a Christ-like manner during practices and games. I realize that unsportsmanlike conduct is inconsistent with how Jesus asks me to behave and that it is the responsibility of my parents, coaches, Athletic Director and Principal to guide me in the pursuit of this goal.
3. I will strive for academic excellence as I realize the priority of developing my mind and investing in my schoolwork. I will submit to the **Athletic Eligibility Policy** set for Heritage Christian School.
4. I will strive to be a godly role model for other students at Heritage Christian School by upholding school rules and interacting respectfully with students and authority figures. I realize I am a leader and will act accordingly submitting to the **Behavior Eligibility Policy** set for athletes at Heritage Christian School.
5. I will respectfully submit to the authority of Heritage Christian School coaches and his/her decisions regarding my participation on the athletic team. If a concern arises, I agree to faithfully follow the principles outlined by Jesus in Matthew 18 and reinforced in the **Protocol for the Resolution of Concern of Grievance Policy**.
6. I will respectfully submit to the authority of game officials and his/her decisions regarding my participation in the game.
7. I will faithfully attend all practices and games submitting to the **Practice/Game Attendance Policy**. Any expected absence from practice must be submitted in writing, preferably before practice that day. Those athletes not attending practice (unexcused absence) will not be allowed the same amount of playing time as those who attend all the practices.

I understand the expectations written above and commit, before God, to uphold them to the best of my ability.

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Parent Signature

Date

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Athlete Signature

Date

# Insurance Waiver

## Purpose:

Every student athlete must present a completed Insurance Waiver or verification of school insurance in order to practice or take part in interscholastic athletics. This form is a statement from parents indicating they do not have school insurance.

\_\_\_\_\_ IS NOT COVERED BY SCHOOLS INSURANCE.  
(Please **print** athlete's name.)

IT IS OUR UNDERSTANDING THAT **HERITAGE CHRISTIAN SCHOOL**, ITS ATHLETIC DEPARTMENT, AND ITS BOARD OF DIRECTORS WILL NOT ASSUME THE RESPONSIBILITY OR OBLIGATION FOR ANY MEDICAL BILLS OR DEBTS RESULTING FROM ANY INJURY TO THE ABOVE NAMED PLAYER WHILE PRACTICING OR PLAYING IN ANY PRACTICE SESSION, SCRIMMAGE, OR CONTEST.

Please check the appropriate space below:

\_\_\_\_\_ We do have private insurance for this athlete.

\_\_\_\_\_ We do not have private insurance for this athlete.

\_\_\_\_\_ Name of Insurance Company

\_\_\_\_\_ Policy Number

\_\_\_\_\_ Date \_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Printed Name of Parent/Legal Guardian

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Telephone

# Part I - Emergency Medical Authorization

## Purpose:

For parents/guardians to authorize emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached.

For \_\_\_\_\_

Name of Athlete

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone. \_\_\_\_\_

Name of School: Heritage Christian School

Parent/Legal Guardian \_\_\_\_\_

Work Telephone# \_\_\_\_\_

In the event reasonable attempts to contact me \_\_\_\_\_ (parent/guardian) are unsuccessful, I (We), the undersigned parent/legal guardian of \_\_\_\_\_, do authorize any hospital, clinic, or licensed physician to treat my/our child and administer any x-ray examination, anesthetic, or surgical diagnosis rendered under the general or special supervision of any member of the medical staff of the hospital, clinic, or office.

Our preferred physician is \_\_\_\_\_ whose phone# is \_\_\_\_\_

Our preferred dentist is \_\_\_\_\_ whose phone# is \_\_\_\_\_

Our preferred hospital is \_\_\_\_\_

In the event the designated preferred practitioner is not available, we authorize in advance another licensed physician or dentist the authority and power to render care in his/her best judgment and the transfer of the child to any hospital reasonably accessible. It is also understood that every effort shall be made to contact the parent/legal guardian prior to rendering treatment to the patient, but that treatment will not be withheld if the parent/guardian cannot be contacted. Permission is also granted for the school's athletic director or coach to provide emergency treatment to my/our child prior to his/her admission to any medical facility.

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date

List of restrictions/physical impairments:

List of special medication taken by child:

# IOWA ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION

## ARTICLE VII 36.14(1) PHYSICAL EXAMINATION.

Every year each student (grades 7-12) shall present to the student's superintendent a certificate signed by a licensed physician and surgeon, osteopathic physician and surgeon, osteopath, qualified doctor of chiropractic, licensed physician assistant, or advanced registered nurse practitioner, to the effect that the student has been examined and may safely engage in athletic competition. *This certificate of physical examination is valid for the purposes of this rule for one (1) calendar year. A grace period, not to exceed thirty (30) days, is allowed for expired certifications of physical examination.*

### QUESTIONNAIRE FOR ATHLETIC PARTICIPATION (Please type or neatly print this information)

Student's Name \_\_\_\_\_ Male \_\_\_ Female \_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

Home Address (Street, City, Zip) \_\_\_\_\_ School District \_\_\_\_\_

Parent's/Guardian's Name \_\_\_\_\_ Date \_\_\_\_\_ Phone # \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone # \_\_\_\_\_

**HEALTH HISTORY** (The following questions should be completed by the student-athlete with the assistance of a parent or guardian. A parent or guardian is required to sign on the other side of this form after the examination.)

- | Yes       | No    | Does this student have / ever had?                               | Yes       | No    | Does this student have / ever had?   |
|-----------|-------|--|-----------|-------|--|
| 1. _____  | _____ | Allergies to medication, pollen, stinging insects, food, etc.?   | 20. _____ | _____ | Head injury, concussion, unconsciousness?  |
| 2. _____  | _____ | Any illness lasting more than one (1) week?                      | 21. _____ | _____ | Headache, memory loss, or confusion with contact?  |
| 3. _____  | _____ | Asthma or difficulty breathing during exercise?                  | 22. _____ | _____ | Numbness, tingling or weakness in arms or legs with contact?                               |
| 4. _____  | _____ | Chronic or recurrent illness or injury?                          | *****     |       |  |
| 5. _____  | _____ | Diabetes?  | 23. _____ | _____ | Severe muscle cramps or illness when exercising in the heat?                               |
| 6. _____  | _____ | Epilepsy or other seizures?                                      | *****     |       |  |
| 7. _____  | _____ | Eyeglasses or contacts?  | 24. _____ | _____ | Fracture, stress fracture or dislocated joint(s)?  |
| 8. _____  | _____ | Herpes or MRSA?  | 25. _____ | _____ | Injuries requiring medical treatment?  |
| 9. _____  | _____ | Hospitalizations (Overnight or longer)?                          | 26. _____ | _____ | Knee injury or surgery?  |
| 10. _____ | _____ | Marfan Syndrome?   | 27. _____ | _____ | Neck injury?   |
| 11. _____ | _____ | Missing organ (eye, kidney, testicle)?                           | 28. _____ | _____ | Orthotics, braces, protective equipment?   |
| 12. _____ | _____ | Mononucleosis or Rheumatic fever?                                | 29. _____ | _____ | Other serious joint injury?  |
| 13. _____ | _____ | Seizures or frequent headaches?                                  | 30. _____ | _____ | Painful bulge or hernia in the groin area?   |
| 14. _____ | _____ | Surgery?   | 31. _____ | _____ | X-rays, MRI, CT scan, physical therapy?  |
| *****     |       |  | *****     |       |  |
| 15. _____ | _____ | Chest pressure, pain, or tightness with exercise?                | 32. _____ | _____ | <b>Has a doctor ever denied or restricted your participation in sports for any reason?</b> |
| 16. _____ | _____ | Excessive shortness of breath with exercise?                     | 33. _____ | _____ | <b>Do you have any concerns you would like to discuss with your health care provider?</b>  |
| 17. _____ | _____ | Headaches, dizziness or fainting during, or after, exercise?     |           |       |  |
| 18. _____ | _____ | Heart problems (Racing, skipped beats, murmur, infection, etc.?) |           |       |  |
| 19. _____ | _____ | High blood pressure or high cholesterol?                         |           |       |  |

- Family History:**
34. \_\_\_\_\_ Does anyone in your family have Marfan syndrome?
35. \_\_\_\_\_ Has anyone in your family died of heart problems or any unexpected/unexplained reason before the age of 50?
36. \_\_\_\_\_ Does anyone in your family have a heart problem, pacemaker or implanted defibrillator?
37. \_\_\_\_\_ Has anyone in your family had unexplained fainting, seizures, or near drowning?
38. \_\_\_\_\_ Does anyone in your family have asthma?
39. \_\_\_\_\_ Do you or someone in your family have sickle cell trait or disease?

Use this space to explain any "YES" answers from above (questions #1-38) or to provide any additional information:

\_\_\_\_\_

40. Are you allergic to any prescription or over-the-counter medications? *If yes, list:* \_\_\_\_\_  
41. List all medications you are presently taking (including asthma inhalers & EpiPens) and the condition the medication is for:  
A. \_\_\_\_\_ B. \_\_\_\_\_ C. \_\_\_\_\_

42. Year of last known vaccination: Tdap (Tetanus): \_\_\_\_\_ Meningitis: \_\_\_\_\_ Influenza: \_\_\_\_\_

43. What is the most and least you have weighed in the past year? **Most** \_\_\_\_\_ **Least** \_\_\_\_\_

44. Are you happy with your current weight? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_ *If no, how many pounds would you like to lose or gain?*  
Lose \_\_\_\_\_ Gain \_\_\_\_\_

### FOR FEMALES ONLY:

1. How old were you when you had your first menstrual period? \_\_\_\_\_

2. How many periods have you had in the last 12 months? \_\_\_\_\_

**PHYSICAL EXAMINATION RECORD** (To be completed by a licensed medical professional as designated in Article VII 36.14(1).)

Athlete's Name \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_ / \_\_\_\_\_ (Repeat, if abnormal \_\_\_\_\_ / \_\_\_\_\_) Vision R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_

	<b><i>NORMAL</i></b>	<b><i>ABNORMAL FINDINGS</i></b>	<b><i>INITIALS</i></b>
1. Appearance (esp. Marfan's )			
2. Eyes/Ears/Nose/Throat			
3. Pupil Size (Equal/Unequal)			
4. Mouth & Teeth			
5. Neck			
6. Lymph Nodes			
7. Heart (Standing & Lying)			
8. Pulses (esp. femoral)			
9. Chest & Lungs			
10. Abdomen			
11. Skin			
12. Genitals - Hernia			
13. Musculoskeletal - ROM, strength, etc. (See questions 24-31)			
14. Neurological			

**Comments regarding abnormal findings:** \_\_\_\_\_

**LICENSED MEDICAL PROFESSIONAL'S ATHLETIC PARTICIPATION RECOMMENDATIONS**  
(Please be precise when indicating at which level the student is cleared to participate.)

- FULL & UNLIMITED PARTICIPATION**
- LIMITED PARTICIPATION** - May **NOT** participate in the following (checked):  
 Baseball    Basketball    Bowling    Cross Country    Football    Golf    Soccer  
 Softball    Swimming    Tennis    Track    Volleyball    Wrestling
- CLEARANCE PENDING DOCUMENTED FOLLOW UP OF** \_\_\_\_\_
- NOT CLEARED FOR ATHLETIC PARTICIPATION DUE** \_\_\_\_\_

Licensed Medical Professional's Name (Printed) \_\_\_\_\_ Date of PPE \_\_\_\_\_

Licensed Medical Professional's Signature \_\_\_\_\_ Phone \_\_\_\_\_

**PARENT'S OR GUARDIAN'S PERMISSION AND RELEASE**

I hereby **verify** the accuracy of the information on the opposite side of this form and **give my consent** for the above named student to engage in approved athletic activities as a representative of his/her school, except those activities indicated above by the licensed professional. I **also give my permission** for the team's physician, certified athletic trainer, or other qualified personnel to give first aid treatment to my son or daughter at an athletic event in case of injury/illness and to share necessary information about the injury/illness with appropriate school personnel.

Name of Parent or Guardian, or student if 18 years of age (Printed) \_\_\_\_\_ Signature of Parent of Guardian, or student if 18 years of age \_\_\_\_\_

Address (Street/PO Box, City, State, Zip) \_\_\_\_\_ Phone Number \_\_\_\_\_

# HEADS UP: Concussion in High School Sports

The Iowa Legislature passed a new law, effective July 1, 2011, regarding students in grades 7 – 12 who participate in extracurricular interscholastic activities. Please note this important information from Iowa Code Section 280.13C, Brain Injury Policies:

- (1) A child must be immediately removed from participation (practice or competition) if his/her coach or a contest official observes signs, symptoms, or behaviors consistent with a concussion or brain injury in an extracurricular interscholastic activity.
- (2) A child may not participate again until a licensed health care provider trained in the evaluation and management of concussions and other brain injuries has evaluated him/her and the student has received written clearance from that person to return to participation.
- (3) Key definitions:
  - “**Licensed health care provider**” means a physician, physician assistant, chiropractor, advanced registered nurse practitioner, nurse, physical therapist, or athletic trainer licensed by a board.
  - “**Extracurricular interscholastic activity**” means any extracurricular interscholastic activity, contest, or practice, including sports, dance, or cheerleading.

## What is a concussion?

A concussion is a brain injury. Concussions are caused by a bump, blow, or jolt to the head or body. Even a “ding,” “getting your bell rung,” or what seems to be a mild bump or blow to the head can be serious.

## What parents/guardians should do if they think their child has a concussion?

1. **OBEY THE NEW LAW.**
  - a. Keep your child out of participation until s/he is cleared to return by a licensed healthcare provider.
  - b. Seek medical attention right away.
2. Teach your child that it’s not smart to play with a concussion.
3. Tell all of your child’s coaches and the student’s school nurse about ANY concussion.

## What are the signs and symptoms of a concussion?

You cannot see a concussion. Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days after the injury. If your teen reports one or more symptoms of concussion listed below, or if you notice the symptoms yourself, keep your teen out of play and seek medical attention right away.

## STUDENTS:

If you think you have a concussion:

- **Tell your coaches & parents** – Never ignore a bump or blow to the head, even if you feel fine. Also, tell your coach if you think one of your teammates might have a concussion.
- **Get a medical check-up** – A physician or other licensed health care provider can tell you if you have a concussion, and when it is OK to return to play.
- **Give yourself time to heal** – If you have a concussion, your brain needs time to heal. While your brain is healing, you are much more likely to have another concussion. It is important to rest and not return to play until you get the OK from your health care professional.

## IT’S BETTER TO MISS ONE CONTEST THAN THE WHOLE SEASON.

**IMPORTANT:** Students participating in interscholastic athletics, cheerleading and dance; and their parents/guardians; must annually sign the acknowledgement below and return it to their school. Students cannot practice or compete in those activities until this form is signed and returned.

We have received the information provided on the concussion fact sheet titled, “HEADS UP: Concussion in High School Sports.”

## Signs Reported by Students:

- Headache or “pressure” in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Just not “feeling right” or is “feeling down”

## PARENTS:

### How can you help your child prevent a concussion?

Every sport is different, but there are steps your children can take to protect themselves from concussion and other injuries.

- Make sure they wear the right protective equipment for their activity. It should fit properly, be well maintained, and be worn consistently and correctly.
- Ensure that they follow their coaches’ rules for safety and the rules of the sport.
- Encourage them to practice good sportsmanship at all times.

## Signs Observed by Parents or Guardians:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes
- Can’t recall events prior to hit or fall
- Can’t recall events after hit or fall

Information on concussions provided by the Centers for Disease Control and Prevention.

For more information visit: [www.cdc.gov/Concussion](http://www.cdc.gov/Concussion)

Student’s Signature

Date

Student’s Printed Name

Parent’s/Guardian’s Signature

Date

Student’s Grade

Student’s School