

FOR OFFICE USE ONLY	
<b>Fall:</b> Amount _____	Date _____
Check _____	Cash _____

FOR OFFICE USE ONLY	
<b>Winter:</b> Amount _____	Date _____
Check _____	Cash _____

FOR OFFICE USE ONLY	
<b>Spring:</b> Amount _____	Date _____
Check _____	Cash _____

**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 \_\_\_\_\_ 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 9<sup>th</sup> grade.

9<sup>th</sup> \_\_\_\_\_ 11<sup>th</sup> \_\_\_\_\_

10<sup>th</sup> \_\_\_\_\_ 12<sup>th</sup> \_\_\_\_\_

\* 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 \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

\_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Siblings participating in Athletics/Activites: \_\_\_\_\_

**Athletic Fee: \$200 per activity - Family Maximum: \$700**    Reduced lunch Fee: (\$100) \_\_\_\_\_    Free lunch Fee:(\$50) \_\_\_\_\_

<b>Fall:</b>	Cheerleading	Cross Country	Football	PI Soccer
	Soccer	Girls Swimming	Girls Tennis	Volleyball
<b>Winter:</b>	Basketball	Gymnastics	Hockey	Alpine Ski
	Boys Swimming	Wrestling	PI FI Hockey	Cheerleading
<b>Spring:</b>	Baseball	Lacrosse	Softball	Boys Tennis
	Golf	Track		PI Softball

**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 PARTICIPATE 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.

Date \_\_\_\_\_  
(Month, day and year)

Signed \_\_\_\_\_  
(Signature of parent or guardian)

## HEALTH AND EMERGENCY INFORMATION FOR ATHLETES

Please complete **both sides** of this form. This form must be completed **each year before** the student will be allowed to practice or play.

The physical exam record must be on file with the school prior to a student's participation. Athletes are not allowed to practice until the physical form has been turned into the athletic office.

I further understand that a member school of the MSHSL must adhere to all of the rules and regulations that pertain to the League athletic activities a school may sponsor, but that local rules may be more stringent than MSHSL rule. (See district *Students Rights, Opportunities and Responsibilities and Discipline Guideline*.)

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex \_\_\_\_\_ Grade \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Father \_\_\_\_\_ Work phone \_\_\_\_\_

Mother \_\_\_\_\_ Work phone \_\_\_\_\_

Physician/clinic \_\_\_\_\_ Phone \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Hospital \_\_\_\_\_ Insurance \_\_\_\_\_

Non-parent emergency contact \_\_\_\_\_ Phone \_\_\_\_\_

Date of last physical exam \_\_\_\_\_ (must be within three years) OR Health Questionnaire \_\_\_\_\_ Year 2 \_\_\_\_\_ Year 3

List any health concerns we should be aware of: \_\_\_\_\_

### 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.

- 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 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.
- **A student whose character or conduct violates the Student Code of Responsibilities or is suspended or expelled is not in good standing and is 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 \_\_\_\_\_  
(Month, day, and year)

Signed \_\_\_\_\_  
(Signature of participant)

### 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 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](http://www.fairview.org), e-mail to [privacy@fairview.org](mailto:privacy@fairview.org), or mail to Fairview Privacy Office 2450 Riverside Ave, Minneapolis, MN 55454.

Date \_\_\_\_\_  
(Month, day, and year)

Signed \_\_\_\_\_  
(Parent/guardian signature)

# MSHSL ANNUAL SPORTS HEALTH QUESTIONNAIRE

DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

Name \_\_\_\_\_ Male \_\_\_\_ Female \_\_\_\_ Age \_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Grade \_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

Address \_\_\_\_\_

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

Since your last complete Sports Qualifying Physical Exam with your physician or your year 2 Annual Health Questionnaire, please respond to the following questions:

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 1. Has a doctor restricted your participation in sports for any reason without clearing you to return to sports? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>IMPORTANT HEART HEALTH QUESTIONS ABOUT YOU</b>   |                          |                          |
| 2. Have you passed out or nearly passed out during or after exercise? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you had discomfort, pain, tightness, or pressure in your chest during exercise? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Does your heart race or skip beats (irregular beats) during exercise? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you get light-headed or feel more short of breath than expected during exercise? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had an unexplained seizure? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>IMPORTANT HEART HEALTH QUESTIONS ABOUT YOUR FAMILY</b>   |                          |                          |
| 7. Has anyone in your immediate family died suddenly and unexpectedly for no apparent reason? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, car accident, or Sudden Infant Death Syndrome)? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Has anyone in your immediate family had instances of unexplained fainting, seizures, or near drowning? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. 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? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has anyone in your immediate family been diagnosed with Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT Syndrome, short QT Syndrome, Brugada Syndrome, or catecholaminergic polymorphic ventricular tachycardia? .....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Does anyone in your immediate family under age 50 have a heart problem, pacemaker, or implanted defibrillator? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>MEDICAL RISK QUESTIONS</b>   |                          |                          |
| 13. Have you had infectious mononucleosis (mono) within the last month? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you had a head injury or concussion that still has symptoms like continuing headaches? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you had numbness, tingling, weakness in, or inability to move your arms or legs after being hit or falling? .....  | <input type="checkbox"/> | <input type="checkbox"/> |

**Parents or Legal Guardians – please note:**

- A “YES” answer to any of the above questions will require a clearance note form a physician prior to participation.
- Please list below any health concerns, medications, or allergies that may be important for the coaches or athletic/activities director to know.

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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.)**

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SQPE Due \_\_\_\_/\_\_\_\_/\_\_\_\_ **CLEARED FOR SPORTS** **YES** **NO**