PARK VIEW MIDDLE SCHOOL / ATHLETIC PARTICIPATION FORM

~ All boys and girls participating in Park View athletics must have this card on file prior to the first practice ~

PARENT/GUARDIAN PERMISSION

Student Name: _____ Grade: _____

Birthdate: _____ / _____ / _____

The school board of the Mukwonago Area School District requires that all athletes have insurance coverage prior to any athletic practice or competition. If your son/daughter already has medical insurance coverage, you should state the insurance company and policy number below. If your son/daughter does not have medical insurance coverage, First Agency Inc. is available to all participants.

[ ] I have coverage with _____

[ ] I elect First Agency Inc. (registration forms and information are available on the district website)

- *In the event of an injury during practice or competition, I grant permission for my son/daughter to be given immediate care and transported if necessary.*
- *I agree that my son/daughter is to be responsible for all equipment issued to him/her and to pay for any items which are lost or damaged.*
- *I have read a copy of the athletic rules/regulations and agree that my son/daughter is to abide by the policies as stated in the student handbook. Furthermore, I agree to cooperate and assist with enforcement of the code of conduct.*
- *I have read and understand the preceding and give permission for the above named student to practice, compete, and represent Park View in interscholastic sports except if restricted by a physician.*

Parent/Guardian Signature _____ **Date:** _____

STUDENT CONTRACT

I agree to be responsible for all equipment and fundraising items issued to me. I will pay for any items which are lost or damaged. Furthermore, I understand that I will not be eligible for athletic participation until all such delinquencies are cleared up. I have read the eligibility information and understand its content and agree to abide by the guidelines stated. I agree to abide by the common sense rules of Good Citizenship and Healthy Lifestyles. Furthermore, I agree to cooperate with the school in enforcement of Good Citizenship and Healthy Lifestyle Choices.

Student Signature _____ **Date** _____

Signature of licensed physician, surgeon, physician assistant, or nurse practitioner:

_____

Address: _____

City, State, Zip: _____

Phone: _____ **Date of Exam:** _____

The named student above has been examined and may participate in interscholastic athletics except as follow:

If none, write NONE: _____

Restrictions: _____

_____

_____

Approved for only one year of competition:

_____

☐ Check this box if this is an alternate year physical (valid physical on file at PVMS)

**A physical examination is good for two years from the date of exam*

Check any/all sports that you plan to participate in:

	FALL		WINTER
	Cross Country (Boys/Girls)		Boys' Basketball
	Girls' Basketball		Wrestling
	Gymnastics		Girls' Volleyball
	SPRING		
	Track & Field (Boys/Girls)		
	Tennis (Boys/Girls)		

PARTICIPATION FEE

$100

One time fee per student

ELIGIBILITY REQUIREMENTS

Students must maintain at least a 1.8 grade point average and have no more than 1 F for each 9 week grading period

PARENT & ATHLETE CONCUSSION AWARENESS AGREEMENT

As a Parent and as an Athlete, it is important to recognize the signs, symptoms, and behaviors of concussions. *By signing this form you are stating that you understand the importance of recognizing and responding to the signs, symptoms, and behaviors of a concussion or head injury.*

Parent Agreement

*I _____ have **read** the Parent Concussion and Head Injury Information ("Know your Concussion ABCs") and understand what a concussion is and how it may be caused. I also **understand** the common signs, symptoms, and behaviors. I agree that my child must be removed from practice/play if a concussion is suspected.*

I understand that it is my responsibility to seek medical treatment if a suspected concussion is reported to me.

I understand that my child cannot return to practice/play until providing written clearance from an appropriate health care provider to his/her coach.

I understand the possible consequences of my child returning to practice/play too soon.

Parent/Guardian Signature _____ **Date** _____

Athlete Agreement

*I _____ have **read** the Athlete Concussion and Head Injury Information ("Know your Concussion ABCs") and **understand** what a concussion is and how it may be caused.*

I understand the importance of reporting a suspected concussion to my coaches and my parents/guardian.

I understand that I must be removed from practice/play if a concussion is suspected. I understand that I must provide written clearance from an appropriate health care provider to my coach before returning to practice/play.

I understand the possible consequence of returning to practice/play too soon and that my brain needs time to heal.

Athlete Signature _____ **Date** _____