MID-STATE YOUTH

FOOTBALL & CHEERLEADING CONFERENCE

REGISTRATION PAPERWORK INSTRUCTIONS

Below are instructions on filling out all the league required paperwork and turning it in.

- Save the document prior to filling anything out.
- If possible, open the document in Adobe or another pdf viewer instead of a web browser. When it's time to print everything out, it will print better.
- Start filling this fillable form out electronically on Page 1 so redundant fields further down the form are filled in.
- You can print out the form and fill it out manually, but you will have to fill in a lot of redundant information on each form.
- Please make sure you take the time to look at the supporting educational material on concussions on page 3. Doing so is a requirement of the parent/guardian and athlete. You are signing off that you have both looked it on page 4.
- The WIAA Physical Forms are pages 5-8 and the medial professional you take your child to may have these already. It is a league requirement to use the WIAA forms.
- The WIAA Physical Forms must be signed by a medical professional in order to practice and there are no exceptions if this isn't done by the first practice.
- It is recommended you make your appointment for the physical right away so there aren't any scheduling issues. Traditionally medial professionals are busy at the end of July. With the pandemic I am sure their schedules are even tighter now.
- When finished filling out pages 1-4, print it out to sign it.
- After signing everything, scan and email your completed forms to winneconnegridironclub@gmail.com. You will receive confirmation if everything was filled out properly or if you need anything else.
- If you don't have a scanner, try using the FREE CamScanner app for your Smart Device. The club has used it in the past and it works great to quickly scan something as a PDF!

Thank you for the opportunity to coach your child and we look forward to another great season!
Winneconne Gridiron Club

Mid-State Youth Football & Cheerleading Conference

No. _____

____ Player

____ Cheerleader

OFFICIAL APPLICATION TO PARTICIPATE

Please Print

Registration Date ____________________ Age Sept 1st ____________________ Sign Up Weight ____________________

Name ____ Birth Date ____________________
LAST NAME FIRST NAME MIDDLES INITIAL

Address ____ Phone ____________________
STREET CITY ÚVŒVÒ ZŒÚ

School ____________________ Next Grade ________ Prior Participation? ☐ **No** ☐ **Yes** If yes, how many years ____

Father's Name ____________________ Address ______________________________ Phone ____________________

Mother's Name ____________________ Address ______________________________ Phone ____________________

Primary E-Mail Address ____

Health Insurance Carrier ____

MEDICAL HISTORY

Yes	No		Yes	No		Yes	No	
☐	☐	Asthma	☐	☐	Fractures within past year	☐	☐	Head injuries within past year
☐	☐	Allergies	☐	☐	Dental braces or bridges	☐	☐	Serious illness
☐	☐	Glasses/Contacts						

I/We the parent(s) of the above named candidate for position on a Mid-State Conference team, hereby give my/our approval to our child's participation in any and all activities during the current season. I/We assume all risks and hazards incidental to such participation, including transportation to and from the activities: and I/We do hereby waive, release, absolve, indemnify and agree to hold harmless the local League, the organizers, sponsors, supervisors, participates and persons transporting my/our child, except to the extent and in the amount covered by accident or liability insurance.
I/We will furnish a certified birth certificate of the above named candidate upon request to the league officials.
I/We agree to be financially responsible for League equipment my/our child will receive other than the normal wear and breakage during games and practice and I/We will reimburse the League for the loss and damage to said equipment. I/We give permission for League to validate participant's school grades.

Father's Signature ______________________________ Mother's Signature ______________________________
(One Signature Mandatory)

Father's Occupation ______________________________ Mother's Occupation ______________________________

EMERGENCY MEDICAL RELEASE

I/We the parents give our permission for any emergency medical treatment necessary either on the practice field or on the game field. I/We authorize any hospital and/or physician to perform emergency treatment for any injuries resulting from any scheduled function including the supervised travel to and from said function.

Father's Signature ______________________________ Mother's Signature ______________________________
(One Signature Mandatory)

REGISTRATION CERTIFICATION

ASSIGNMENT		**APPROVAL BY AUTHORIZED OFFICIAL**	
Sizes	Squad (Circle One)	Birth Certificate	Physical Exam
Shoulder Pad Helmet Pants	Jr. Pee Wee Peewee		

FOR ASSOCIATION USE

YES, I WOULD LIKE TO VOLUNTEER TO HELP WITH:			
Coaching	☐	Play Counter	☐
Team Assistant	☐	Picture Day	☐
Equipment Dist.	☐	Game Field Setup	☐
Fundraising	☐	Concessions	☐
Chain Gang	☐	Other	☐

PAYMENTS	
Registration $	Signature
Equipment Deposit $	Signature
Other $	Signature

Do you have a sibling participating in program? ☐ Yes ☐ No

Warning: Injury may result from playing football or cheerleading.

MID-STATE YOUTH FOOTBALL & CHEERLEADING CONFERENCE
20____ EMERGENCY CONTACT &
PARENTAL RELEASE and UNDERSTANDING FORM
(PRINT OR TYPE)

1) This Emergency Contact & Parental Release and Understanding for must be dated, signed and submitted prior to the first practice at the start of the 20___ season. (August 1, 20___)
2) ***No*** players or cheerleaders will be allowed to participate in any Mid-State Youth Football & Cheerleading Conference activities until this form is completed and on file.
3) This form once completed will be kept with each teams medical kit in the event that an emergency situation should arise.

CHILD'S NAME ____

(Last) (First) (Middle Initial)

ADDRESS ____

CITY ____________________ STATE ______________ ZIP ______________

PHONE ____________________

HEALTH INSURANCE CARRIER ______________________________

KNOWN ALLERGIES ____________________ MEDICATION(S) ______________

EMERGENCY PHONE NUMBERS

IN THE EVENT THAT I/WE NEED TO BE REACHED DURING EITHER PRACTICE OR A GAME, YOU MAY REACH ME/US OR THE FOLLOWING AT: (PLEASE LIST **(4)** INCLUDING YOURSELF)

NAME	PHONE #

STATEMENT OF PARENTAL RELEASE AND UNDERSTANDING

We the parent(s)/guardian(s) for the above named participant hereby give my/our approval for our child's participation in any or all activities during the current season. I/We understand and agree to the following items:

1. That the above named is physically fit to play in accordance with the Physical Form we have on file.
2. That I/We assume all risks and hazards incidental to such participation, including transportation to and from any and all activities. I/We understand that injuries may result from playing football or cheerleading. The coaching staff reserves the right, after consultation with the parent(s)/guardian(s), to withhold from further participation in either practice or game any child that they feel is no longer fit to participate.
3. I/We agree to be financially responsible for the equipment my/our child has been issued. I/We will reimburse the **Mid-State Conference and/or local league** that issued the equipment for the loss of and/or damage to said equipment beyond normal wear and breakage.
4. **Mid-State Conference and/or local league** reserves the right to discipline any of its' participants for conduct that is considered inappropriate or detrimental to the program. If such an instance should occur, a conference shall be held with you the parent/guardian and all other parties involved to determine what measures shall be taken including suspension from any/or all further activities. **THE THROWING OF EQUIPMENT SHALL NOT BE TOLERATED**.

EMERGENCY MEDICAL RELEASE

I/We the parent(s)/guardian(s) give our permission for any emergency medical treatment either on the practice or game field. I/We authorize any emergency personnel, hospital and/or physician to perform emergency treatment for any injuries resulting from any scheduled function including the supervised travel to and from said function. I/We agree to be financially responsible through either our health insurance carrier or by another means for any costs incurred due to the providing of emergency medical treatment.

PARENT/GUARDIAN'S SIGNATURE ______________________________ DATE ____________________

Possible Information Sheets

Video: Concussions 101, a Primer for Kids and Parents
https://www.youtube.com/watch?v=zCCD52Pty4A

Coaches:
https://www.wiaawi.org/Portals/0/PDF/Health/ConcussionCoaches.pdf

Parents:
https://www.wiaawi.org/Portals/0/PDF/Health/ConcussionParents.pdf

Athletes:
https://www.wiaawi.org/Portals/0/PDF/Health/ConcussionAthletes.pdf

CDC on Heads Up Athletics:
https://www.cdc.gov/headsup/index.html

Free Online Course on Cucussion:
https://nfhslearn.com/courses/concussion-in-sports-2

Mid-State Youth Football and Cheerleading, Inc.

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MSYFC Community

Statement Acknowledging Receipt of Education and Responsibility to report signs or symptoms of concussion to be included as part of the "Participant and Parental Disclosure and Consent Document".

I,____________________________, of Mid-State Football and Cheerleading, Inc.
Youth Student/Athlete Name
and above named community hereby acknowledge having received education about the signs, symptoms, and risks of sport related concussion. I also acknowledge my responsibility to report to my coaches, parent(s)/guardian(s) any signs or symptoms of a concussion. I certify that I have read, understand, and agree to abide by all of the information contained in this sheet. I further certify that if I have not understood any information contained in this document, I have sought and received an explanation of the information prior to signing this statement.

____

Signature and printed name of student or athlete Date

I, the parent/guardian of the student athlete named above, hereby acknowledge having received education about the signs, symptoms, and risks of sport relatedconcussion. I certify that I have read, understand and agree to abide by all of the information contained in this sheet. I further certify that if I have not understood any information contained in this document, I have sought and received an explanation of the information prior to signing this statement.

____

Signature and printed name of parent/guardian Date

Preparticipation Physical Evaluation
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam ____________________

Name ____________________ Date of birth ____________________

Sex ________ Age ________ Grade ________ School ____________________ Sport(s) ____________________

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: ____________		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: ____________		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete ____________________ Signature of parent/guardian ____________________ Date ____________

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HE0503 9-2681/0410

Preparticipation Physical Evaluation

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam ____

Name ______________________________________ Date of birth ______________

Sex _______ Age __________ Grade _____________ School ___________________ Sport(s) ______________________

1. Type of disability
2. Date of disability
3. Classification (if available)
4. Cause of disability (birth, disease, accident/trauma, other)
5. List the sports you are interested in playing

	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

____

____

____

____

____

Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

____

____

____

____

____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete ____________________ Signature of parent/guardian ______________________________ Date ____________

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■ Preparticipation Physical Evaluation
PHYSICAL EXAMINATION FORM

Name ______________________________ Date of birth ______________

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height　　　Weight　　　☐ Male　☐ Female		
BP　　/　　(　　/　　)　Pulse　　Vision R 20/　　L 20/　　Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart [a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic [c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ______________________________

____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports ______________________________

  Reason ______________________________

Recommendations ______________________________

____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) ______________________________ Date ______________

Address ______________________________ Phone ______________

Signature of physician ______________________________ MD or DO/PA/APNP

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■ Preparticipation Physical Evaluation
CLEARANCE FORM

WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION – ATHLETIC PERMIT CARD

(Print or Type)

ALL STUDENTS PARTICIPATING IN INTERSCHOLASTIC ATHLETICS MUST HAVE THIS CARD ON FILE AT THEIR SCHOOL PRIOR TO PRACTICE OR PARTICIPATION

Physical examination taken April 1 and thereafter is valid for the following two school years; physical examination taken before April 1 is valid only for the remainder of that school year and the following school year.

NAME (Last) ________________________ (First) ____________________ (Middle Initial) _______ Date of Birth _______________

Age ______ Sex ______ Grade _____ School ________________________________ City __________________________

Present Address ____ Telephone ____________________

❑ Cleared without restriction **❑ Cleared, with the following qualifications:** ___________________________________

____

❑ Not cleared **❑ Pending further evaluation** **❑ For all sports** **❑ For certain sports:** __________________________

Reason: ____

Recommendations: ____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of Physician (Print/Type) ____

SIGNATURE OF LICENSED PHYSICIAN (MD OR DO)/PA/APNP*: ____

Clinic Name ____

Address/Clinic ______________________________ City ____________________ State _______ Zip Code __________

Telephone ____ Date of Examination ______________________

* Physicians may authorize Nurse Practitioners to stamp this card with the physician's signature or the name of the clinic with which the physician is affiliated.

Parents' Place of Employment ____

Family Physician ______________________________ Family Dentist ______________________________

Name of Private Insurance Carrier ____ Telephone ________________

Subscriber Member Name (Primary Insured) ____

Emergency Information

Allergies ____

Other Information (medication, etc.) ____

Immunizations **❑ Up to date (see attached documentation)** **❑ Not up to date - specify** __________________________
(e.g., tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis; pneumococcal; meningococcal; varicella)

1. I hereby give my permission for the above named student to practice and compete and represent the school in WIAA approved interscholastic sports except those restricted on this card.

2. Pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder (collectively known as "HIPAA"), I authorize health care providers of the student named above, including emergency medical personnel and other similarly trained professionals that may be attending an interscholastic event or practice, to disclose/exchange essential medical information regarding the injury and treatment of this student to appropriate school district personnel such as but not limited to: Principal, Athletic Director, Athletic Trainer, Team Physician, Team Coach, Administrative Assistant to the Athletic Director and/or other professional health care providers, for purposes of treatment, emergency care and injury record-keeping.

SIGNATURE OF PARENT/GUARDIAN ____ DATE ____________________