Walled Lake Performance Ensemble

2020 - 2021 WLP: **BACKGROUND CHECK AND MEDICAL FORMS**

** All forms must be completed by a parent or guardian if student is not 18 **

☐ WLP FORM C

- Criminal Background Check.
- Must be filled out by ANYONE volunteering and you will be with students or on campus.
- If you have already filled one out for this year, please add a note on the form indicating this.

☐ WLP FORM E

- Allergy and Medication Permission Form.
- List any known allergies or medical conditions.
- Gives the WLPE permission to give over the counter medicine that you indicate on the form.

☐ WLP FORM F

- Authorization to Administer Medication.
- Gives the WLPE permission to administer any prescribed medication during any WLPE event if need be (we'd prefer this be handled by a parent/guardian though).

☐ MHSAA HEALTH QUESTIONNAIRE

- If you have a physical on file with the school from 2019/2020 school year, please complete this form. A new physical form is not needed.
- If you have already completed this form, you do not need to do this. Please indicate somewhere on the form that you have already filled one out for this year.

☐ MHSAA PHYSICAL FORM

- If you don't have a physical on file from the 2019/2020 or 2020/2021 school year, then you can use this form to get a physical.
- If you already have a physical from last year or this year, then you do not need this form.

If you have questions or need clarification, please reach out to:

Nick Pourcho
WLPE Director
nickpourcho@teachers.wlcsd.org

WLPE FORM C

Walled Lake Consolidated Schools
850 Ladd Road
Building D
Walled Lake, MI 48390
248-956-2030
Criminal History/Reference Form

In congruence with the state law for employees and to maintain student safety in Walled Lake Consolidated Schools, anyone convicted of a felony or a misdemeanor criminal sexual offense will not be permitted to volunteer in the school district.

Name _____

Volunteer Job Assignment _____ **Buildings: Walled Lake Consolidated Schools**

Criminal History
PLEASE PRINT

Name:_____
Last First Middle
Maiden Name/Names Previously used:
_____

Driver's License Number: _____
Date of Birth: _____ Race: _____Sex: _____

You are required to fill-out one CRC per year.

I understand that the above information is required by the Central Records Division of the Michigan State Police, Lansing, MI. I authorize Walled Lake Consolidated Schools to utilize the above information for the sole purpose of obtaining a conviction only criminal history file search, pursuant to the Michigan Freedom of Information Act. (PA 442 of 1976).

Volunteer Signature _____ **Date**_____

Telephone #_____

It is the policy of the Walled Lake Consolidated Schools' Board of Education that no person on the basis of race, color, religion, national origin or ancestry, age, sex, marital status or disability shall be discriminated against, excluded from participation in, denied the benefits of or otherwise be subjected to, discrimination in any program or activity.

WLPE FORM E

Allergy / Medical Condition & OTC Medication Permission Form
Walled Lake Performance Ensemble 2020-2021 Season

_____, has my permission to receive the "over the counter" medications, as noted below with a check mark, for the duration of the 2020-2021 WLPE Season.

I have listed below any known allergies, treatments, medications, and medical conditions associated with my child.

Signature of Parent / Guardian _____ Date _____
Print Parent / Guardian Name _____ Emergency Phone _____

Allergy / Medical Condition(s)

_____ No Medical Conditions Known
_____ Seasonal Allergies (please list below)
_____ Insect Allergies
_____ Food Allergies (list below)
_____ No Known Allergies

List Daily Meds:
_____
_____
_____

List Any Known Medical Conditions:
_____
_____

OTC Medication Permission

Check all medications your child has your permission to receive

_____ Tylenol (Acetaminophen)
_____ Benadryl (Diphenhydramine) oral
_____ Maalox, Mylanta, or Tums
_____ Imodium
_____ Midol
_____Advil/Motrin (Ibuprofen)
_____Calamine Lotion
_____Claritin
_____Sudafed
_____Aleve

Date	Time	Medication	Dose	Reason	Initials

Administrators' Signatures: (print name and sign)

_____ _____

_____ _____

WLPE FORM F

JGFGB-R JGFGB-R-13

AUTHORIZATION TO ADMINISTER MEDICATION

Permission Form for Prescribed Medication and Over-the-Counter Medication.
This Authorization is Valid for the Current School Year Only.

TO BE COMPLETED BY THE PARENT/GUARDIAN

Student: _____ Date of Birth: _____ Grade: _____

School: _____ Teacher/Classroom: Nick Pourcho/WLPE

I have read the policy and regulations pertaining to administration of medication. I request that (name of student) _____ receive the medication specified below at school according to standard school policy. I understand the parent is required to deliver medication to school.

_____ _____

Date Parent/Guardian Signature

Self Administration: High school students may self administer medication. Elementary and middle school students may self administer only emergency medications such as Epi Pens and inhalers with the approval of the parent and physician. I request that (name of student) _____ be allowed to self-administer the medication below at school according to school policy.

_____ _____

Date Parent/Guardian Signature

TO BE COMPLETED BY THE PHYSICIAN OR AUTHORIZED PRESCRIBER:

Name of Medication: _____

Reason for Medication (optional): _____

Form of Medication/Treatment: ☐ Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer
☐ Other _____

Instructions: (Times and dose to be given at school): _____

Start: ☐ Date form received ☐ Other date: _____

Stop: ☐ End of school year ☐ Other date/duration: _____

Restrictions and/or adverse reactions:

☐ None anticipated ☐ Yes. Please describe: _____

_____

Special storage requirements: ☐ None ☐ Refrigerate Other: _____

This student is both capable and responsible for self-administering this medication.
☐ No ☐ Yes, Supervised ☐ Yes, Unsupervised
This student may carry this medication: ☐ Yes ☐ No

PLEASE PRINT:

Physician's Name: _____ Date: _____

Address: _____

Phone Number: _____ Physician's Signature: _____

Office Use Only:
Date received: _____ **Received by:** _____
Administrative Approval: _____

7/8/96 Rev. 8/21/97, 6/18/98, 3/4/04, 8/16/07

This Sports Health Questionnaire may only be used for students who received a valid sports physical during the 2019-20 school year (one completed on or after April 15, 2019). ***A school may require a student to have a valid physical exam.***

2020-21 MHSAA SPORTS HEALTH QUESTIONNAIRE

Date ____/_____/_____

Name _____ Age_____ Birth Date_____/_____/_____

Grade _____School_____Sport(s)_____

Address _____

Phone _____ Date of Last Sports Qualifying Physical Exam _____/_____/_____

Check Yes or No for each question.

Since your last complete Sports Qualifying Physical Exam with your physician, HAVE YOU HAD ANY OF THE FOLLOWING?

		YES	NO
1.	Has a doctor ever restricted or denied your participation in sports for any reason without clearing you to return to sports?	___	___
2.	Do you have a heart condition or has a doctor ever told you that you had an abnormal heart test (e.g., ECG, echocardiogram)?	___	___
3.	In the last year, have you ever passed out or nearly passed out during or after exercise?	___	___
4.	In the last year, have you had discomfort, pain, tightness, or pressure in your chest during exercise?	___	___
5.	In the last year, did your heart race, flutter in your chest or skip beats (irregular beats) during exercise?	___	___
6.	In the last year, did you get light-headed or feel more short of breath than expected during exercise?	___	___
7.	In the last year, have you had an unexplained seizure?	___	___
8.	In the last year, has anyone in your immediate family died suddenly and unexpectedly for no apparent reason?	___	___
9.	In the last year, has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 (including an unexplained drowning or an unexplained car accident)?	___	___
10.	In the last year, has anyone in your immediate family had instances of unexplained fainting, seizures, or near drowning?	___	___
11.	In the last year, has anyone in your immediate family been diagnosed with a genetic heart problem such as hypertrophic cardio-myopathy (HCM), Marfan Syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long or short QT Syndrome, Brugada Syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?	___	___
12.	In the last year, has anyone in your immediate family before age 35 had a heart problem, pacemaker, or implanted defibrillator?	___	___
13.	In the last year, have you had a head injury or concussion that still has symptoms like continuing headaches, concentration problems or memory problems?	___	___
14.	In the last year, has a doctor restricted or denied your participation in sport due to a serious injury or medical condition without clearing you to return to sports?	___	___

Parents or Legal Guardians: Please note below any health concerns, medications, or allergies that may be important for the coaches and/or athletic director to know (attach additional notes if space below does not allow for complete comments). Schools may require a student to have a valid physical exam at their discretion.

_____

_____

_____

I do not know of any existing physical or additional health reasons 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 Guardian or 18-Year-Old Signature **Student Signature** **Date**

FOR ATHLETIC DIRECTOR USE: A YES answer to any of the above questions requires a physical exam from a MD, DO, NP, PA prior to participation.

____ INFORMATION IS COMPLETE **____ STUDENT REQUIRES FOLLOW-UP**

Reference: Preparticipation Physical Evaluation (Fifth Edition): AAFP, AAP, ACSM, AMSSM, AOSSM, AOASM; AAP, 2019

- (DETACH HERE IF NEEDED TO ACCOMPANY STUDENT-ATHLETE) -

EMERGENCY INFORMATION: COMPLETED BY PARENT or GUARDIAN or 18 YEAR OLD

Student:_____Grade: _____ Doctor: _____ Phone: (_____)_____

IN EMERGENCY (1):_____Home #: (_____)_____Cell #: (_____)_____

IN EMERGENCY (2):_____Home #: (_____)_____Cell #: (_____)_____

Drug Reactions:_____Current Medications: _____

Allergies:_____

michigan high school athletic association

MHSAA SPORTS HEALTH QUESTIONNAIRE - CONSENT - INSURANCE

Shaded headline areas are to be completed by student, parent/guardian or 18 year old

There are **FOUR** (4) signatures on this page (4) to be completed by student, parent/guardian and/or 18-year-old

Student Name: _____ (last) _____ (first) _____ (middle initial)

Student Address: _____ (street) _____ (city) _____ (zip)

Gender: ___ M ___ F Age:___ Date of Birth:_____ Place of Birth (City/State):_____

School:_____ Grade:_____

Father/Guardian Name: _____

Phone (home):_____ (work):_____ (cell):_____

Mother/Guardian Name: _____

Phone (home):_____ (work):_____ (cell): _____

Email Address: Parent/Guardian/18-Year-Old:_____

STUDENT PARTICIPATION & PARENT or GUARDIAN or 18 YEAR OLD CONSENT

The information submitted herein is truthful to the best of my knowledge. By my/my child's signature below, **I/we acknowledge that I/we have received concussion educational information that meets Michigan Department of Health and Human Services and MHSAA requirements**.

Further, in consideration of my/my child's participation in MHSAA-sponsored athletics, I/we do hereby agree, understand, appreciate, and acknowledge: **that participation in such athletics is purely voluntary; that such activities involve physical exertion and contact and that there is inherent risk of personal injury associated with participation in such activities, which risk I/we assume;** and that I/we agree to, and hereby waive any and all claims, suits, losses, actions, or causes of action against the MHSAA, its members, officers, representatives, committee members, employees, agents, attorneys, insurers, volunteers, and affiliates based on any injury to me, my child, or any person, whether because of inherent risk, accident, negligence, or otherwise, during or arising in any way from my/my child's participation in an MHSAA-sponsored sport.

I/we understand that I am/we are expected to adhere firmly to all established athletic policies of my school district and the MHSAA. I/we hereby give my consent for the above student to engage in interscholastic athletics and for the disclosure to the MHSAA of information otherwise protected by FERPA and HIPAA for the purpose of determining eligibility for interscholastic athletics. My child has my permission to accompany the team as a member on its out-of-town trips.

(1) Signature of **STUDENT**:_____ Date: _____

(2) Signature of **PARENT** or **GUARDIAN** or **18-YEAR-OLD**:_____ Date: _____

INSURANCE STATEMENT

Our son/daughter will comply with the specific insurance regulations of the school district.

The student-athlete has health insurance: ___ YES ___ NO

If YES, Family Insurance Co:_____ Insurance ID #: _____

Additionally, I hereby state that, to the best of my knowledge, my answers to the medical health questions (see reverse) are complete and correct.

(3) Signature of **PARENT** or **GUARDIAN** or **18-YEAR-OLD**:_____ Date: _____

- (DETACH HERE IF NEEDED TO ACCOMPANY STUDENT-ATHLETE) -

MEDICAL TREATMENT CONSENT: COMPLETED BY PARENT or GUARDIAN or 18 YEAR OLD

I,_____, an 18-year-old, or the parent or guardian of_____, recognize that as a result of athletic participation, medical treatment on an emergency basis may be necessary, and further recognize that school personnel may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the then-existing circumstances and to assume the expenses of such care.

(4) Signature of **PARENT** or **GUARDIAN** or **18-YEAR-OLD**:_____ Date: _____

michigan high school athletic association

MEDICAL HISTORY: Completed by Parent or Guardian or 18-Year-Old

Student Name: _____ Date of Birth: _____

Doctor: _____ Doctor's Phone: _____ Date of Exam: _____

- GENERAL QUESTIONS	Y	N
Has a doctor ever denied or restricted your participation in sports for any reason?		
Do you have any ongoing medical conditions? If so, please identify below:		
❑ Asthma ❑ Anemia ❑ Diabetes ❑ Infections ❑ Other:		
Have you ever spent the night in the hospital or have you ever had surgery?		
- HEART HEALTH QUESTIONS ABOUT YOU	**Y**	**N**
Have you ever passed out or nearly passed out DURING or AFTER exercise?		
Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
Does your heart ever race or skip beats (irregular beats) during exercise?		
Has a doctor ever told you that you have any heart problems? Check all that apply:		
❑ High blood pressure ❑ Heart murmur ❑ Heart infection ❑ High cholesterol		
❑ Kawasaki disease ❑ Other:		
Has a doctor ordered a test for your heart? (example, ECG/EKG, echocardiogram)		
Do you get lightheaded or feel more short of breath than expected during exercise?		
Do you have a history of seizure disorder or had an unexplained seizure?		
Do you get more tired or short of breath more quickly than your friends during exercise?		
- HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Y**	**N**
Has anyone in your family had unexplained fainting, unexplained seizures or near drowning?		
Does anyone in your family have a heart problem, pacemaker or implanted defibrillator?		
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)?		
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?		
- BONE AND JOINT QUESTIONS	**Y**	**N**
Have you ever had an injury to a bone, muscle, ligament or tendon that caused you to miss a practice or a game?		
Have you ever had any broken or fractured bones, dislocated joints or stress fracture?		
Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast or crutches?		
Do you regularly use a brace, orthotics or other assistive device?		
Do you have a bone, muscle or joint injury that bothers you?		
Do any of your joints become painful, swollen, feel warm or look red?		
Do you have any history of juvenile arthritis or connective tissue disease?		
Have you ever had an x-ray for neck instability or atlantoaxial instability (Down syndrome or dwarfism)?		

- MEDICAL QUESTIONS	Y	N
Do you cough, wheeze or have difficulty breathing during or after exercise?		
Have you ever used an inhaler or taken asthma medicine?		
Is there anyone in your family who has asthma?		
Were you born without, or missing a kidney, eye, testicle (males), spleen or any other organ?		
Do you have groin pain or a painful bulge or hernia in the groin area?		
Have you had infectious mononucleosis (mono) within the last month?		
Do you have any rashes, pressure sores or other skin problems?		
Have you had a herpes or MRSA skin infection?		
Do you have headaches or get frequent muscle cramps when exercising?		
Have you ever become ill while exercising in the heat?		
Do you or someone in your family have sickle cell trait or disease?		
Have you had any problems with your eyes or vision or any eye injuries?		
Do you wear glasses or contact lenses?		
Do you wear protective eyewear such as goggles or a face shield?		
Immunization History: Are you missing any recommended vaccines?		
Do you have any allergies?		
Have you ever had a head injury or concussion?		
Do you have any concerns that you would like to discuss with a doctor?		
Have you ever received a blow to the head that caused confusion, prolonged headache or memory problems?		
Have you ever had numbness, tingling, weakness or inability to move your arms or legs after being hit or falling?		
Have you ever had an eating disorder?		
Do you worry about your weight?		
Are you trying to or has anyone recommended that you gain or lose weight?		
Are you on a special diet or do you avoid certain types of foods?		
- FEMALES ONLY (Optional)	**Y**	**N**
Have you ever had a menstrual period?		
How old were you when you had your first menstrual period?		
How many periods have you had in the last 12 months?		

CURRENT-YEAR PHYSICAL = GIVEN ON OR AFTER APRIL 15 OF THE PREVIOUS SCHOOL YEAR

PHYSICAL EXAMINATION & MEDICAL CLEARANCE: Completed by MD, DO, PA or NP - RETURN DIRECTLY TO PATIENT

EXAMINATION: Height: Weight: ❑ Male ❑ Female BP: / Pulse: Vision: R 20/ L 20/ Corrected: ❑ Y ❑ N

MEDICAL	NORMAL	ABNORMAL	MUSCULOSKELETAL	NORMAL	ABNORMAL
Appearance: Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)			Neck		
Eyes/Ears/Nose/Throat: Pupils Equal Hearing			Back		
Lymph nodes			Shoulder/Arm		
Heart: Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (PMI)			Elbow/Forearm		
Pulses: Simultaneous femoral and radial pulses			Wrist/Hand/Fingers		
Lungs			Hip/Thigh		
Abdomen			Knee		
Genitourinary (males only)			Leg/Ankle		
Skin: HSV: Lesions suggestive of MRSA, tinea corporis			Foot/Toes		
Neurologic			Functional Duck Walk		

RECOMMENDATIONS: _____

I certify that I have examined the above student and recommend him/her as being able to compete in supervised athletic activities NOT crossed out below.

BASEBALL – BASKETBALL – BOWLING – COMPETITIVE CHEER – CROSS COUNTRY – FOOTBALL – GOLF – GYMNASTICS – ICE HOCKEY
LACROSSE – SKIING – SOCCER – SOFTBALL – SWIMMING/DIVING – TENNIS – TRACK & FIELD – VOLLEYBALL – WRESTLING

EXAMINER

Name of Examiner (print/type): _____ Date: _____

Signature of Examiner: _____ (Check One): ❑ MD ❑ DO ❑ PA ❑ NP

- (DETACH HERE IF NEEDED TO ACCOMPANY STUDENT-ATHLETE) -

EMERGENCY INFORMATION: COMPLETED BY PARENT or GUARDIAN or 18-YEAR-OLD

Student: _____ Grade: _____ Doctor: _____ Phone: (_____)_____

IN EMERGENCY (1): _____ Home #: (_____)_____ Cell #: (_____)_____

IN EMERGENCY (2): _____ Home #: (_____)_____ Cell #: (_____)_____

Drug Reactions: _____ Current Medications: _____

Allergies: _____

michigan high school athletic association

PRE-PARTICIPATION PHYSICAL - CONSENT - INSURANCE

Shaded headline areas are to be completed by student, parent/guardian or 18-year-old

There are **FOUR** (4) signatures on this page ➡ 4 ⬅ to be completed by student, parent/guardian and/or 18-year-old

A CURRENT-YEAR PHYSICAL IS ONE GIVEN ON OR AFTER APRIL 15 OF THE PREVIOUS SCHOOL YEAR

Student Name: _____
LAST FIRST MIDDLE INITIAL

Student Address: _____
STREET CITY ZIP

Gender: ❑ M ❑ F Age: _____ Date of Birth: _____ Place of Birth (City/State): _____

School: _____ Circle Grade: **6 7 8 9 10 11 12**

Father/Guardian Name: _____

Phone (home): _____ (work): _____ (cell): _____

Mother/Guardian Name: _____

Phone (home): _____ (work): _____ (cell): _____

Email Address: Parent/Guardian/18-Year-Old: _____

STUDENT PARTICIPATION & PARENT or GUARDIAN or 18-YEAR-OLD CONSENT

The information submitted herein is truthful to the best of my knowledge. By my/my child's signature below, **I/we acknowledge that I/we have received concussion educational information that meets Michigan Department of Health and Human Services and MHSAA requirements**.

Further, in consideration of my/my child's participation in MHSAA-sponsored athletics, I/we do hereby agree, understand, appreciate, and acknowledge: **that participation in such athletics is purely voluntary; that such activities involve physical exertion and contact and that there is inherent risk of personal injury associated with participation in such activities, which risk I/we assume;** and that I/we agree to, and hereby waive any and all claims, suits, losses, actions, or causes of action against the MHSAA, its members, officers, representatives, committee members, employees, agents, attorneys, insurers, volunteers, and affiliates based on any injury to me, my child, or any person, whether because of inherent risk, accident, negligence, or otherwise, during or arising in any way from my/my child's participation in an MHSAA-sponsored sport.

I/we understand that I am/we are expected to adhere firmly to all established athletic policies of my school district and the MHSAA. I/we hereby give my consent for the above student to engage in interscholastic athletics and for the disclosure to the MHSAA of information otherwise protected by FERPA and HIPAA for the purpose of determining eligibility for interscholastic athletics. My child has my permission to accompany the team as a member on its out-of-town trips.

➡ 1 ⬅ Signature of **STUDENT**: _____ Date: _____

➡ 2 ⬅ Signature of **PARENT** or **GUARDIAN** or **18-YEAR-OLD**: _____ Date: _____

INSURANCE STATEMENT

Our son/daughter will comply with the specific insurance regulations of the school district.

The student-athlete has health insurance: ❑ YES ❑ NO

If YES, Family Insurance Co: _____ Insurance ID #: _____

Additionally, I hereby state that, to the best of my knowledge, my answers to the medical history questions (see reverse) are complete and correct.

➡ 3 ⬅ Signature of **PARENT** or **GUARDIAN** or **18-YEAR-OLD**: _____ Date: _____

- (DETACH HERE IF NEEDED TO ACCOMPANY STUDENT-ATHLETE) -

MEDICAL TREATMENT CONSENT: COMPLETED BY PARENT or GUARDIAN or 18-YEAR-OLD

I, _____, an 18-year-old, or the parent or guardian of _____, recognize that as a result of athletic participation, medical treatment on an emergency basis may be necessary, and further recognize that school personnel may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the then-existing circumstances and to assume the expenses of such care.

➡ 4 ⬅ Signature of **PARENT** or **GUARDIAN** or **18-YEAR-OLD**: _____ Date: _____