Dear Parents:

Thank you for your interest in Flandreau Indian School as a potential choice to educate your student. The admissions application checklist is to be used as a guide, to provide the information the school needs to review your student’s application.

The deadline for submitting applications is **August 31, 2018**. **Only applications accompanied with required documents will be date stamped and reviewed for admissions.** Required documents are listed on the bottom half of page 2.

The following decisions are possible:
1. Accepted
2. Denied

These items are the most difficult to obtain and will hold up the process of your application.
1. Certified Degree of Indian Blood *(Tribal Membership cards are not accepted)*
2. Contact your current school’s registrar (before they close for the summer) to get an official transcript or a certificate of 8th grade completion and achievement test scores.
3. **Physical Exam is REQUIRED for all students, new applicants and applicants reapplying, must be completed after MAY 1, 2018, see pages 19-26.** Students should start calling now for a physical exam appointment.
4. Students interested in participating in competitive athletics may be required to complete an application for hardship for the SDHSAA. Application for hardship **does not** guarantee eligibility. Eligibility is determined solely by the SDHSAA.
5. **STUDENTS INTERESTED IN PARTICIPATING IN SPORTS AT FIS MUST BE ON CAMPUS AUGUST 20TH, the first day of school, TO PARTICIPATE IN SPORTS.** If student is not here on the first day of school they will have to wait 45 days to participate in any sports. **NO EXCEPTIONS.**

**FIRST DAY OF SCHOOL—AUGUST 20, 2018. TRAVEL ARRANGEMENTS WILL BE MADE BY THE FLANDREAU INDIAN SCHOOL AT OUR EXPENSE. IF YOU DO NOT TRAVEL WHEN IT IS PROVIDED FOR YOU, YOU WILL BE RESPONSIBLE FOR YOUR OWN TRANSPORTATION TO SCHOOL.**

When the application is completed, please mail to:

Flandreau Indian School  
Admissions  
1132 N. Crescent St.  
Flandreau, SD 57028
Flandreau Indian School Admissions Application Checklist

ALL APPLICATIONS MUST HAVE THE FOLLOWING LIST OF DOCUMENTS

THE ADMISSIONS COMMITTEE WILL NOT REVIEW INCOMPLETE APPLICATIONS

STUDENT: ___________________________ Grade applying for: ___________________________

DATE: ___________________________ School year: ___________________________

Student Enrollment Application

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<td>Pg. 16</td>
<td>Consent for Medical Treatment</td>
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<td>Pg. 17</td>
<td>Flandreau Indian School Physical Examination Form</td>
</tr>
<tr>
<td>PHYS—1 to 5</td>
<td>SDHSAA Annual Physical Examination Forms</td>
</tr>
</tbody>
</table>

(NOTE: THE SDHSAA Annual Physical must be completed ONLY if Participating in sports)

**Following documents are required before the application can be processed**

<table>
<thead>
<tr>
<th>Copy of State Issued Birth Certificate</th>
<th>Copy of Social Security Card</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copy of Certified Degree of Indian Blood (Tribal Membership card not accepted)</td>
<td>Copy of Health/Medical Insurance Cards</td>
</tr>
<tr>
<td>Flandreau Physical Form (no sports) pg. 20</td>
<td>Immunization record/2nd MMR</td>
</tr>
<tr>
<td>Physical Forms pgs. 21—24 if sports</td>
<td></td>
</tr>
</tbody>
</table>

ALL students must provide reports cards showing completion of grade 8th through December and **FINAL** grades in May

Students applying for grades 10-12 must **ALSO** provide transcript with GPA

COURT APPOINTED PARENT OR LEGAL GUARDIAN MUST PROVIDE LEGAL DOCUMENTATION.
An application signed by the student as parent or legal guardian will not be accepted, even if The student is 18 years of age or older.
United States Department of Interior
Bureau of Indian Education

Student Enrollment Application
For Bureau Funded Schools and Federal Boarding Schools

2018—2019

DATE: ________________

Name of School: FLANDREAU INDIAN SCHOOL Grade Applying for: ___________
Day Student ( ) Dorm Student ( )

(PLEASE PRINT OR TYPE)

I. IDENTIFICATION

Social Security Number: ________________
Name of Student: ________________________________________________________________

_________________________________  First  ____________  Middle

Address: ________________________________________________________________

City: __________________________ State: __________ Zip Code: __________

Student Cell phone # (if applicable): ________________________________

Date of Birth: ____/____/____ Hospital or Clinic Used: _______________ Chart#: __________

Place of Birth: ______________________________________ Sex: Male ( ) Female ( )

Student resides with: Mother ( ) Father ( ) Legal Guardian ( ) other ( ) __________

Tribal Affiliation: __________________________ Degree Indian: __________

Enrollment Number: __________________________ Home Agency: __________________

Dominant Language: ________________________________________________

Student attended FIS previously? Yes ( ) No ( )
If yes, please list dates__________________________________________________________

siblings attending FIS presently or previously? ________________________________

__________________________________________________________
Student's Name: __________________________

FAMILY AND BACKGROUND INFORMATION: (PLEASE PRINT OR TYPE)

IMPORTANT - PLEASE NOTIFY THE ADMISSIONS OFFICE IMMEDIATELY IF ADDRESS OR PHONE NUMBERS CHANGE!

Parent(s) or Legal Guardian(s) - Circle one
Father: ___________________________ Mother: ___________________________
Address: ___________________________ Address: ___________________________
Tribal Affiliation: ___________________________ Tribal Affiliation: ___________________________
Occupation: ___________________________ Occupation: ___________________________
Employer: ___________________________ Employer: ___________________________
Telephone: Work ___________________________ Telephone: Work ___________________________
Home ___________________________ Home ___________________________
Email ___________________________ Email ___________________________
Cell ___________________________ Cell ___________________________

If you are the court appointed custodial parent, you must attach appropriate documentation
(if parents do not live in the same house, please indicate if non-custodial parent can receive mailings by completing address information)

GUARDIAN INFORMATION (IF OTHER THAN PARENT) - MUST PROVIDE APPROPRIATE LEGAL DOCUMENTATION

If the student does not live with either parent, complete the following information on the guardian. If the student is a ward of the court, attach documentation and provide information on the person (s) responsible for the applicant who will be the primary contact person. A STUDENT MAY NOT LIST HIMSELF/HERSELF AS GUARDIAN EVEN IF HE/SHE IS 18 YEARS OF AGE

Name: ___________________________
Address: ___________________________
Telephone: Work ___________________________
Home ___________________________
Cell ___________________________
Email ___________________________

PARENT/LEGAL GUARDIAN SIGNATURE: ___________________________
IN CASE OF EMERGENCY, WHOM COULD WE CONTACT (OTHER THAN PARENT/GUARDIAN)

Name: ___________________________ Cell: ___________________________
Home phone: ______________ Work phone: __________ Relationship __________

TRIBAL EDUCATION OFFICE: ___________________________
ADDRESS: ___________________________________________
CITY, STATE, ZIP CODE: ______________________________
TELEPHONE NUMBER: _________________________________

CRITERIA FOR BOARDING SCHOOL:

Favorable action is recommended upon this application because this case confers to the following criteria for boarding school or out of boundary enrollment. If this application is for an off-reservation boarding school and for social reason, a social summary should accompany this application.

Check all applicable criteria (At least one must be checked)

Educational Factors
Federal/Public Schools near students home:
( ) grade level not offered
( ) are severely overcrowded
( ) exceed 1 1/2 mile walking distance to school or bus route.
( ) do not offer special vocational/preparatory training necessary for gainful employment
( ) do not offer adequate provisions to meet academic deficiencies or linguistic/cultural differences.
( ) receiving school offers special program needed by student

Social Factors
In his/her family environment, the student:
( ) was rejected or neglected
( ) does not receive adequate parental supervision.
( ) well being was imperiled due to family.
( ) has behavioral problems too difficult for or local resources.
( ) has siblings or other close relatives enrolled who would be adversely affected by separation.
Flandreau Indian School

Information Form

Student Name: ____________________________________________________________

EDUCATIONAL INFORMATION

1. List school previously attended: __________________________________________

2. Previous school contact number: __________________________________________

2. Reason for leaving: _____________________________________________________

3. Did student miss 15 or more days in the last school year? Yes ( ) No ( )

4. Has student ever been suspended? Yes ( ) No ( ) Expelled? Yes ( ) No ( )
   If yes, date and reason must be given ______________________________________

5. Has student participated in Special Education Program? Yes ( ) No ( )

6. Has student participated in Gifted and Talented Program? Yes ( ) No ( )

7. Was your student eligible for Free and Reduced Meals? Yes ( ) No ( )

8. Will your student participate in Sports at Flandreau Indian School? Yes ( ) No ( ) If so, complete pages 21 through page 24. ALL STUDENTS INTERESTED IN PARTICIPATING IN SPORTS MUST BE PRESENT ON CAMPUS THE FIRST DAY OF SCHOOL OR WILL NOT BE ELIGIBLE TO PLAY SPORTS

SOCIAL INFORMATION

1. Is student a ward of the court? Yes ( ) No ( ) If yes, a copy of the court order must be submitted.

2. Has student ever been arrested? Yes ( ) No ( ) If yes, what was/were the violation(s)? __________________________

3. Has student ever been in jail or a detention center? Yes ( ) No ( ) If yes, how many times?

4. Does student have a probation officer? Yes ( ) No ( )
   Name ________________________________________________________________
   County ______________________________________________________________
   Phone ________________________________________________________________

5. Has student ever received counseling? Yes ( ) No ( )
   Name ________________________________________________________________
   Phone ________________________________________________________________

I, the parent/legal guardian of the above mentioned student hereby certify that the information provided is true and accurate to the best of my knowledge and I understand that Flandreau Indian School will verify all information. **Any false statement or misrepresentation or omission of required information in application will result in denial of application.**

I understand that additional information may be requested to complete my student’s records. Such as: School records, counseling records, and behavior records.

________________________________________  ___________________________________
Student Signature                           Parent/Legal Guardian Signature

PARENT or LEGAL GUARDIAN & STUDENT MUST SIGN FORM
The Family Educational Rights and Privacy Act (FERPA), a Federal law, requires that Flandreau Indian School, with certain exceptions, obtain your written consent prior to the disclosure of personally identifiable information from your child’s education records. However, Flandreau Indian School may disclose appropriately designated “directory information” without written consent, unless you have advised the District to the contrary in accordance with District procedures. The primary purpose of directory information is to allow the Flandreau Indian School to include this type of information from your child’s education records in certain school publications. Examples include:

- A playbill, showing your student’s role in a drama production;
- The annual yearbook; Honor roll or other recognition lists; Graduation programs; and
- Sports activity sheets, such as for wrestling, showing weight and height of team members.

Directory information, which is information that is generally not considered harmful or an invasion of privacy if released, can also be disclosed to outside organizations without a parent’s prior written consent. Outside organizations include, but are not limited to, companies that manufacture class rings or publish yearbooks. In addition, two federal laws require local education agencies receiving assistance under the Elementary and Secondary Education Act of 1965 (ESEA) to provide military recruiters, upon request, with three directory information categories—names, addresses and telephone listings - unless parents have advised the school that they do not want their student’s information disclosed without their prior written consent.

If you do not want Flandreau Indian School disclose directory information from your child’s education records without your prior written consent, you must notify the school in writing. Flandreau Indian School designated the following information as directory information:

- Student’s name, address, telephone listing, Photograph, Date and place of birth, Electronic mail address.
- Participating in officially recognized activities and sports, weight and height of member of athletic teams
- Degrees, honors, and awards received, Major field of study
- Dates of attendance, Grade level, the most recent educational agency or institution attended

If there are questions about your or your student’s (18 or older) rights under FERPA, you may contact the office at Flandreau Indian School.

If you do not wish directory information about your student to be disclosed please indicate on the attached form and return that form to the Flandreau Indian School.
Family Educational Rights and Privacy Act (FERPA)

I have received information about my rights under FERPA and understand my right to request that any of the items listed below not be disclosed as Directory Information to any outside group, other than those having a legal right to the information, without my written permission. Those having a legal right might include federal auditors, those having oversight responsibilities, circumstances regarding health and safety, emergencies or other similar entities.

[ ] I do not want any Directory Information regarding _____________________________.

(Student Name)
(Nothing will be disclosed without written Permission)

OR

I, do not want the following directory information regarding my student _____________________________.

(Student Name)
disclosed without written permission.

Check all that apply.

1. [ ] Student’s name
2. [ ] Participation in officially recognized activities and sports
3. [ ] Address
4. [ ] Telephone listing
5. [ ] Weight and height of members of athletic teams
6. [ ] Electronic mail address
7. [ ] Photograph
8. [ ] Degrees, honors, and awards received
9. [ ] Date and place of birth
10. [ ] Major field of study
11. [ ] Dates of attendance
12. [ ] Grade level

I am the parent or legal guardian of: _____________________________.

I am an eligible student (18 years old or older) _____________________________.

_________________________________________  _____________________________.
Signature                                               Date
Parents,

The “No Child Left Behind Act of 2002”, SEC.9528, Armed Forces Recruiter Access to Student and Student Recruiting Information, provides for schools to provide, on request made by military recruiters or an institution of higher education, access to secondary school student names, addresses, and telephone listings. As a school, we are required to comply with this law. You as a parent, however, have the right to request that the school not release that information to these agencies. If you wish to not have your child’s information released, please indicate below. If you have any questions about the “No Child Left Behind Act of 2002” please contact Flandreau Indian School.

_____ I do wish to have my child’s information released.

_____ I do not wish to have my child’s information released.

________________________________________________________________________
Signature of Parent/Legal Guardian                      Date
Flandreau Indian School
Admission and Continuing Enrollment Criteria

Student’s Name: ________________________________

- Students **must be making academic progress** throughout the school year at Flandreau Indian School. Students failing to make academic progress will be placed on academic probation. Grades will be reviewed at the end of each semester to determine progress. The student will be given until the end of the next semester to make improvements.

- Students may not miss more than 10 unexcused days of school per academic year.

__________________________  ________________
Student Signature          Date

**ICU Academic Program**

The ICU program allows students more practice time for completing their assignments. ICU is during the student’s lunch and study hall as well as after school. During ICU the student can get one on one help with a teacher or an education technician to complete their class work. You will be contacted when your child is placed on the ICU list.

**Contact Information**

PARENT CELL NUMBER: ________________________________
PARENT EMAIL ADDRESS: ________________________________
STUDENT CELL NUMBER: ________________________________
STUDENT EMAIL ADDRESS: ________________________________

I, ________________________________ agree for reasonable cause and essential to assuring the health and safety of all students at the Flandreau Indian School, staff, acting in attendance in loco parentis, may at their discretion exercise search, seizure, and drug testing while my student is in attendance at Flandreau Indian School. Such activities shall be in compliance with 25CFR-part 42.3, (b), (Rights of the Individual Students) and 34 CFR-part 86.200 (b-e) (Drug Free School and Campuses).

__________________________  ________________
Parent/Legal Guardian Signature          Date

**PARENT or LEGAL GUARDIAN & STUDENT MUST SIGN FORM**
INDIVIDUAL EDUCATIONAL PROGRAMS

Student participated in Special Education: YES _____ NO _____
Student was on a 504 Plan: YES _____ NO _____
Student participated in Gifted and Talented: YES _____ NO _____
Student participated in LEP: YES _____ NO _____

Has your student ever been on an Individual Education Plan (IEP) for Special Education? If yes, please indicate your child’s disability:

_______ Cognitive Impairment
_______ Emotional Disturbance
_______ Learning Disability
_______ Speech or Language Impairment
_______ Other Health Impairment

Please contact the school that last implemented your child’s and have them forward the Special Education Records to the Flandreau Indian School. This is extremely important. It will assist the staff in planning an appropriate program for your student.

I am legally responsible for this student and hereby understand that additional information may be requested by the Exceptional Education Department concerning my child’s Individual Education Program or 504 Plan.

________________________________________
Parent/Legal Guardian Signature

The Flandreau Indian School, in cooperation with the Bureau of Education (BIE) funded schools, will ensure that a free and appropriate education and a full educational opportunity is provided in the least restrictive environment to all children with disabilities, grades 9 through 12.
United States Department of the Interior
BUREAU OF INDIAN AFFAIRS
FLANDREAU INDIAN SCHOOL
FLANDREAU, SOUTH DAKOTA 57028

Gifted and Talented Education Program

Parental Consent for Testing/Evaluation

Dear Parents/Guardian,

This letter is to inform you that ________________, your child could be referred/nominated to be assessed for the Flandreau Indian School Gifted and Talented Program. Your parental consent for testing and evaluation will be required. Although, a test or an evaluation will be administered, any other available supporting data will need to be submitted. These documents will be utilized to screen your child and to determine their eligibility for placement within the program. To qualify for the gifted and talented program for academic aptitude, the student has to score in the eighty-sixth percentile or higher nationally on the Northwest Evaluation Association assessment.

If your child qualifies for the Gifted and Talented Program, they will be provided weekly Gifted and Talented services. The Gifted and Talented Program is designed to challenge and strengthen the academic and creative needs of your daughter.

You have the option to have your child tested and evaluated. Please sign the appropriate statement below:

______ Yes, I give my parental consent for my child to be tested and evaluated and documents collected to determine eligibility for the Gifted and Talented Program. I also give my parental consent to place your son or daughter in the Gifted and Talented Program at Flandreau Indian School.

______ No, I do not give my parental consent for my daughter to be tested and evaluated for the Gifted and Talented Program.

Parent/Guardian: ____________________________ Date: ___ / ___ / ___
Flandreau Indian School
McKinney-Vento Act
Student Residency Questionnaire

The purpose of this form is to address the requirements of the McKinney-Vento Act, Title X Part C of the No Child Left Behind Act. This document will be used to share with school staff and partnering agencies to ensure all providers have the necessary information to support the child and his/her family.

Name of Student:_________________________ Gender: Male____ Female____

Please check only ONE that best describes where the student is presently living (Please specify name of hotel, shelter, or organization providing the transitional housing)

- In my own home or apartment.
- In the home of a friend or relative because I lost my housing. (fire, flood, lost job, divorce, domestic violence, kicked out by parents, parent in the military was deployed, parent(s) in jail.) Name/address of person with whom you live with (full name required) ____________________________

- In a shelter because I do not have permanent housing. (living in a family shelter, domestic violence shelter or children/youth shelter) Name, address and phone # of the shelter:

- In Transitional housing (housing that is available for a specific length of time only and is partly or completely paid by a church, a nonprofit organization or some other organization) Name, address and phone # of housing program and organization providing housing:

- In a hotel or motel (because of economic hardship, eviction, cannot get deposits for permanent housing) Name of hotel or motel, address & phone of where you are staying.

In unsHELTERED care (living in a car, park, campground) Provide where you are living such as where your car is parked:

- In housing that does not have plumbing, electricity or heat. (circle which is missing)

- Awaiting foster care placement.

- None of the above describes my current living situation. Briefly describe your situation.__________________________________________

Name of parent/guardian or person who student resides: ____________________________

Address:_________________________ City:_________________________ State:________

Cell #________________ Work#________________ Shelter#________________ Friend#________________

__________________________________________ Parent/guardian signature 

_______ date
Flandreau Indian School Student and Family Language Survey

Student Name ___________________________ Grade ______________

Gender: Female ____ Male ____ Date of Birth ________________

Parent/Guardian’s Name ________________________________

Parent/Guardian’s Name ________________________________

Select all of the races that apply to the student

_____ Native American  _____ Caucasian  _____ Hispanic  _____ Asian

_____ Native Hawaiian/Pacific Islander

Registered Tribal Member of ___________________________ Other Tribe(s)______________________

What was student’s first language? __________________________

Is a language other than English used in the home? ____ Yes  ____ No

If so, what language? ____________________________________

Does the student speak any languages other than English? ____ Yes  ____ No

If so, what language and at what level?  Language __________________________

_____ Beginning, few words and phrases  _____ Intermediate, conversational

_____ Advanced, comprehends commonly used terms  _____ Fluent

If a second language is not spoken in the home, has the student been regularly exposed
to a second language by a family member? If so, how would you describe the student’s exposure
to the language? Consistent, occasional, rare? Please describe.

________________________________________________________________________

What relation is this family member who exposes the student to a language other than English?
(grandparent, great-grandparent, aunt, uncle, etc.)

________________________________________________________________________

Did your child attend a language immersion school prior to this year? If so, where and for how long? What language?

________________________________________________________________________

Can you provide any additional information about your child’s second language skills?

________________________________________________________________________
MEDICAL INFORMATION

Does the student have any medical problems that may interfere with school attendance and/or needs medical care while in school? Yes____ No____ If yes, please explain:

Special needs or treatments (nebulizer, pacemaker, diagnostic checks, wheelchair, other..) If Yes, list:

Is the student taking medications on a regular basis? Yes____ No____ If yes, list:
Medication: __________________________ Condition __________________________
Medication: __________________________ Condition __________________________
Medication: __________________________ Condition __________________________

Is the student allergic to any medications or foods? Yes____ No____ If yes, list:
________________________________________________________________________
Type of reaction: __________________________________________________________

Immunization Records: Provide the most up-to-date records for review.

Fax any “new” shots given prior to starting school to the FIS school nurse at Fax# 605-997-2287

Two MMR Requirement - two vaccinations are required by the state of SD in order to start kindergarten. Make sure to provide documentation that those 2 shots have been given or your child may not start at FIS until verification is provided. If you cannot locate documentation for the 2nd shot - another must be given.

All Flandreau Indian School staff is authorized to act in Loco Parentis for the students at the Flandreau Indian School. The FIS staff has authority to sign all paperwork required for emergency, medical or hospital care at any medical facility.

FYI: Definition - In Loco Parentis:

In loco parentis is a term used in situations where another individual or agency is acting in place of a parent on behalf of a minor. The term is used in legal settings to assign the rights, duties and responsibilities of a parent to another person or agency. Alternatively, the term has been used in less formal references to describe the role played by an educational institution, such as a boarding school, college, or university, in supervising minors and young adults.

NOT PROVIDING OR PROVIDING FALSE INFORMATION MAY RESULT IN YOUR CHILD’S IMMEDIATE RELEASE FROM THE FLANDREAU INDIAN SCHOOL.

____ I give consent for my child to receive the annual Seasonal Influenza Vaccine provided through the school. The Influenza Virus is an annual shot that boosts an individual’s immune system to provide protection against the virus in the event that he/she would be exposed to the Influenza virus. The vaccine should lessen the severity of symptoms that one would experience and lessen the number of days that one would be sick; thereby missing less school. In past years some strains of Influenza have affected communities more severely, even causing death in healthy children and adults. The influenza vaccine is recommended for those residing in close living quarters.

MEDICATION

With my full consent, the Flandreau Indian School has my permission to administer medication to the student.

I (we), as parent(s)/legal guardian(s), have read this consent form for the Flandreau Indian School and fully understand and agree to its content.

Signature of Parent/Guardian __________________________ Date __________________________
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
PUBLIC HEALTH SERVICE  
INDIAN HEALTH SERVICE

CONSENT OF PARENT OR LEGAL GUARDIAN OR OTHER PERSON WITH PRIMARY RESPONSIBILITY FOR THE CARE OF THE CHILD

Person is defined as one who in the absence of the parent or legal guardian provides a home for the child such as next of kin.

SSN _____ - _____ - ________ (Send a copy of the SS Card with this form)

Name of student: __________________________ Date of Birth: ________

I (We), ________________________________ have read the Consent Form for the Indian Health to arrange for or to provide the following health services for this child:

1. Health care including medical exams, routine laboratory studies, x-ray procedures, and skin tests.
2. Dental care including dental exams, preventative use of fluorides and necessary emergency dental care.
3. Mental Health services including evaluation and treatment necessary.
4. Emergency health care for accidents or illnesses.
5. Transportation of the child to and/or from another health care facility for these services.

______ I hereby give consent for all of the above services.

______ Exceptions or Special Instructions:

_________________________________________________________________________

_________________________________________________________________________

Parent/Guardian signature ________________________________

Address _______________________________________________

City, State, Zip __________________________________________

Relationship to Student ___________________________________

Date __________________________ Valid Until ________________

(The above signature, address, relationship-to and date are required for validity)

All Flandreau Indian School staff is authorized to act in Loco Parentis for the students at the Flandreau Indian School. The FIS staff has authority to sign all paperwork required for emergency, medical or hospital care at any medical facility.

Definition – In Loco Parentis

In loco parentis is a term used in situations where another individual or agency is acting in place of a parent on behalf of a minor. The term is used in legal settings to assign the rights, duties and responsibilities of a parent to another person or agency. Alternatively, the term has been used in less formal references to describe the role played by an educational institution, such as a boarding school, college, or university in supervising minors and young adults.
Flandreau Indian School
Physical Examination

Name__________________________________________ Other names used________

Date of Birth____/____/_____ Sex: M____ F____ Age____ Ht____ Wt #_____

<table>
<thead>
<tr>
<th>Normal</th>
<th>Abnormal</th>
<th>Not Evaluated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ears</td>
<td></td>
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<tr>
<td>Teeth</td>
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<tr>
<td>Glands</td>
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<tr>
<td>Heart</td>
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<tr>
<td>Lungs</td>
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<tr>
<td>Abdomen</td>
<td></td>
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<tr>
<td>Posture</td>
<td></td>
<td></td>
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<tr>
<td>Genitals</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Physical findings which are of significance to the School:

Recommendations or Restrictions:

Pulse _______ BP _______ Eye Screening: L _______ R _______

List Allergies (food, medication, other):

Type of reaction: _______________________________ Treat reaction with:

If student uses an Epi Pen or Benadryl – student MUST bring updated medication to school with them.

Immunizations: Record any immunizations given at this office visit – list type and date:
Attach a copy of immunization record(s) for review – MUST show documentation of 2 MMRs.

Last Eye Exam by an optometrist: Month________ Year________ Other________

The Flandreau Tribal Clinic does not provide contacts or contact-exams.

___ Uses glasses: __________ Contacts:

Significant Personal Medical History with dates: (Current medications/diagnosis, asthma, anemia, birth control, h/o fractures, plates/pins, surgeries, hospitalizations, concussions, prosthetic). MUST bring current medications to school.

Social/Behavioral Health History: (Current medications/diagnosis, ADD/ADHD, anxiety, insomnia, dates of behavioral hospitalizations or CD treatment). MUST bring current medications to school.

Signature: Examining Medical Provider __________________________ Date__________

Medical Facility __________________________

Address/City/State __________________________ Ph#_____________
PHYSICAL EXAMINATION INSTRUCTIONS

I. Requirement of School Boards.
   A. Each governing board shall decide if the exam is to be repeated on an annual basis, on a biennial basis or triennial basis.
   B. Each governing board shall decide whether they want the doctors to evaluate sexual maturity based upon the Tanner Maturation Index. Please white-out item 13 on the Physical Exam form if the decision is NOT to use the Tanner Maturation Index.

II. Requirements of Member Schools.
   A. Each member school shall make copies of the forms that must be completed by the parents and/or doctors in sufficient quantities to meet your needs.
   B. Member schools must keep on file the following:
      1. A copy of the PARENT PERMIT FORM. This form must be submitted annually.
      2. A copy of the INITIAL PRE-PARTICIPATION HISTORY report for each student who takes the comprehensive exam for the first time. This form must be made available to the medical examiner at the time the student takes his/her first physical exam.
      3. A copy of the INTERIM PRE-PARTICIPATION HISTORY for each student must be submitted annually by the parents except on the very first occasion when the INITIAL PRE-PARTICIPATION HISTORY is required.
         All questions on the INTERIM PRE-PARTICIPATION HISTORY form should be answered with the following in mind: IN THE PAST YEAR: Please explain any yes answers in the space provided on the form. Any yes answers may require a re-visit to the medical provider for re-certiﬁcation of health. The parent/guardian signature denotes that the student is physically able to participate.
      4. A copy of the comprehensive PHYSICAL EXAMINATION signed by either a Doctor of Medicine, Doctor of Osteopathy, Doctor of Chiropractic, Physician Assistant or Nurse Practitioner.
   C. Member schools may commence scheduling physical exams as early as April 1 for the ensuing school year.

III. Role of Doctors, Physician Assistant and Nurse Practitioners.
   A. The certification/signing of the physical exam form is reserved for only a Doctor of Medicine, Doctor of Osteopathy, Doctor of Chiropractic, a Physician Assistant or Nurse Practitioner. Stamping the name of a medical clinic or a medical association as a substitute for the authorized signature is unacceptable. All exams must be signed by authorized medical personnel as listed in paragraph two above.
   B. The examiner shall receive a copy of Instructions for conducting the orthopedic screening and other portions of the exam. The instruction sheet follows the other forms located in this section of this publication.
   C. The medical history form must be made available to the person(s) conducting the physical exam at the time the examination takes place.

Revised 03-18
SOUTH DAKOTA HIGH SCHOOL ACTIVITIES ASSOCIATION

PHYSICAL EXAMINATION
ITEMS TO BE EVALUATED

Station 1 - Individual History

All YES items in the history are reviewed in detail to determine if they constitute a risk to participation by the athlete, or need additional evaluation.

Station 2 - Blood Pressure

Right arm, sitting. Values needing recheck and possible further evaluation are:

Under 11 Years 130/75
12 years and older 140/85

Station 3 - Vision (Snellen)

Uncorrected vision less than 20/200, corrected vision less than 20/40 requires further evaluation.

Station 4 - Skin, Mouth, Eyes, Ears

Pustular acne, herpes or other infections, athlete's foot; braces, dental prostheses, severe caries, pupil inequality, contacts; ear drainage, malformation.

Station 5 - Chest

Review of cardiac-related history. Heart enlargement, pulse discrepancy, murmurs, abnormal rhythm, forced expiratory maneuver, evidence of latent bronchospasm.

Station 6 - Lymphatics, Abdomen, Genitalia

Cervical or axillary adenopathy, organomegaly, absence of testicles, and hernia (males only).

Station 7 - Orthopedic

Asymmetry, scoliosis, swelling or deformity, decreased range of motion or strength

Station 8 - Review

CLEARANCE

_____ Cleared for ALL (collision, contact/endurance sports, and other sports)

_____ Cleared only for contact/endurance sports and other sports

_____ Cleared only for other sports

Definition: [Collision=Football and Wrestling]; [Contact/Endurance Sports=Basketball, Cross Country, Gymnastics, Soccer, Tennis, Track, Volleyball, Competitive Cheer and Competitive Dance]; [Other Sports=Golf]

_____ Cleared for ALL, but with recommendations for further evaluation or treatment for ______________________

_____ Above clearance to be granted only after ______________________________

_____ Clearance cannot be given at this time because ______________________________

Revised 03-18

PHYS - 1A
<table>
<thead>
<tr>
<th>Athletic Activity (Instructions)</th>
<th>Observation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stand Facing Examiner</td>
<td>General habitus; acromioclavicular joints</td>
</tr>
<tr>
<td>Look at ceiling, floor, over both shoulders; touch ears to shoulders</td>
<td>Cervical spine motion</td>
</tr>
<tr>
<td>Shrug shoulders (examiner resists)</td>
<td>Trapezius strength</td>
</tr>
<tr>
<td>Abduct shoulder 90 degrees (examiner resists at 90 degrees)</td>
<td>Deltoid strength</td>
</tr>
<tr>
<td>Full external rotation of arms</td>
<td>Shoulder motion</td>
</tr>
<tr>
<td>Flex and extend elbows</td>
<td>Elbow motion</td>
</tr>
<tr>
<td>Arms at sides, elbow 90 degrees flexed, pronate and supinate wrists</td>
<td>Elbow and wrist motion</td>
</tr>
<tr>
<td>Spread fingers; make fist</td>
<td>Hand or finger motion and deformities</td>
</tr>
<tr>
<td>Tighten (contact) quadriceps; relax quadriceps</td>
<td>Symmetry and knee effusion; ankle effusion</td>
</tr>
<tr>
<td>&quot;Duck walk&quot; four steps (away from the examiner with buttocks on heels)</td>
<td>Hip, knee and ankle motion</td>
</tr>
<tr>
<td>Back to examiner; knees straight, touch toes</td>
<td>Shoulder symmetry; scoliosis, hip motion, hamstring tightness</td>
</tr>
<tr>
<td>Raise up on toes, raise heels</td>
<td>Calf symmetry, leg strength</td>
</tr>
</tbody>
</table>

May require reflex hammer, tape measure, pin, and examination table.
SOUTH DAKOTA HIGH SCHOOL ACTIVITIES ASSOCIATION
ANNUAL PARENT OR GUARDIAN PERMIT

I hereby give my consent for ________________________ . GRADE _______
Name (Please Print) ____________________________ . 2018-19 School Year

who was born at ____________________________________________
City, Town, County, State

on __________________ to compete in SDHSAA approved athletics for ______________________ High School
Date of Birth

during the 2018-19 school year.

I/We give our permission for our son/daughter to participate in organized high school athletics, realizing that such activity
involves the potential for injury which is inherent in all sports.

Date __________________, 20______ Signed ________________________ Parent or Legal Guardian

THIS FORM MUST BE COMPLETED ANNUALLY AND MUST BE AVAILABLE FOR INSPECTION AT THE SCHOOL.

INITIAL PRE-PARTICIPATION HISTORY

SEE REVERSE SIDE FOR
HEALTH HISTORY QUESTIONNAIRE

Revised 03-18

PHYS – 1B
# 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**

**Sex**

**Age**

**Grade**

**School**

**Sport(s)**

**Date of birth**

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

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Allergy</th>
<th>Other</th>
</tr>
</thead>
</table>

Do you have any allergies?  □ Yes  □ No  If yes, please identify specific allergy below.

□ Medicines  □ Pollen  □ Food  □ Stinging insects

** Explain “Yes” answers below. Circle questions you don’t know the answers to.**

### GENERAL QUESTIONS

1. Has a doctor ever denied or restricted your participation in sports for any reason?  □ Yes  □ No

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

5. Have you ever passed out or nearly passed out during or after exercise?  □ Yes  □ No

6. Have you ever had chest 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  □ Heart murmur  □ High cholesterol  □ 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 light-headed or feel more short of breath than expected during exercise?

11. Have you ever had an unexplained seizure?

12. Do you feel more tired or short of breath more quickly than your friends during exercise?

### HEART HEALTH QUESTIONS ABOUT YOUR FAMILY

13. Has any family member or relative died of heart problems or had an unexpected or unplanned 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

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?

**Explain “yes” answers here**

<table>
<thead>
<tr>
<th>Medical Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes  □ No</td>
</tr>
</tbody>
</table>

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 (male), your spleen, or any other organ?

30. Do you have groin pain or a painful lobe 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 seizures 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 ever had any problems with your eyes or vision?

44. Have you ever had 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 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 menstrual periods have you had in the last 12 months?

**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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Revised 03-18

PHYS – 1B
**SOUTH DAKOTA HIGH SCHOOL ACTIVITIES ASSOCIATION**
**PHYSICAL EXAMINATION FORM**

**NAME ___________________________ GRADE ______ DATE OF BIRTH ____________**

**CHECK ONE: _____ MALE _____ FEMALE (2018-19 School Year)**

1. Blood pressure (sitting) _______/______ Repeat in 5 minutes, if elevated _______/______.

2. Height _________________________

3. Weight _________________________

4. Vision 20/_______ (L) 20/_______ (R) Normal Abnormal COMMENTS

5. Head ___________________________

6. Mouth (dentures, braces?) ________________________________

7. Eyes (contacts?) ________________________________

8. Chest/lung ___________________________

9. Heart
   a. Heart sounds _______________________
   b. Murmurs __________________________
   c. Pulse (rad. vs fem.) ________________
   d. Rhythm ___________________________

10. Abdomen
    a. Liver or spleen _____________________
    b. Masses ___________________________

11. Genitalia (males only)
    a. Hernias __________________________
    b. Testes ___________________________

12. Orthopedic
    a. Cervical spine _____________________
    b. Shoulder shrug ____________________
    c. Deltoid ___________________________
    d. Arms/elbow _______________________
    e. Hands ____________________________
    f. Hips ______________________________
    g. Knees ______________________________
    h. Ankles ____________________________
    i. Scoliosis __________________________

**SPORTS PARTICIPATION RECOMMENDED FOR:**

_____ Cleared for ALL (collision, contact/endurance sports, and other sports)

_____ Cleared only for contact/endurance sports and other sports

_____ Cleared only for other sports

**Definition:** [Collision=Football and Wrestling]; [Contact/Endurance Sports=Basketball, Cross Country, Gymnastics, Soccer, Tennis, Track, Volleyball, Competitive Cheer and Competitive Dance]; [Other Sports=Golf]

_____ Cleared for ALL, but with recommendations for further evaluation or treatment for __________________________

_____ Above clearance to be granted only after __________________________

_____ Clearance cannot be given at this time because __________________________

**NAME OF EXAMINER (PRINT) __________________________ DATE ____________, 20__

**SIGNATURE OF EXAMINER**

**NOTE:** The following licensed medical personnel are qualified to perform the examination and certify the health of the student athlete: Doctor of Medicine, Doctor of Osteopathy, Doctor of Chiropractic, licensed Physician Assistant and licensed Nurse Practitioner.

**Revised 03-18**

**PHYS – 1C**
SOUTH DAKOTA HIGH SCHOOL ACTIVITIES ASSOCIATION
ANNUAL PARENT OR GUARDIAN PERMIT

I hereby give my consent for ___________________________ to compete in SDHSAA approved athletics for ___________________________ High School during the 2018-19 school year.

I/We give our permission for our son/daughter to participate in organized high school athletics, realizing that such activity involves the potential for injury which is inherent in all sports.

Signed ___________________________ Date __________, 20__

Parent or Legal Guardian

THIS FORM MUST BE COMPLETED ANNUALLY AND MUST BE AVAILABLE FOR INSPECTION AT THE SCHOOL.

INTERIM PRE-PARTICIPATION HISTORY
(Used in conjunction with the Biennial/Triennial examination.)

SEE REVERSE SIDE FOR
HEALTH HISTORY QUESTIONNAIRE
INTERIM PRE-PARTICIPATION HISTORY
(Used in conjunction with the Biennial/Triennial examination.)

NAME ____________________________ GRADE _______ DATE OF BIRTH _______
(2018-19 School Year) YES NO

IN THE PAST YEAR: YES NO
1. Has a doctor denied your participation in sports for any reason? 
2. Do you have a new ongoing medical condition (like diabetes or asthma)?
3. Are you currently taking any new prescription or non-prescription (over-the-counter) medicines or pills?
4. Do you have new allergies to medicines, pollens, foods, or stinging insects?
5. Have you passed out or nearly passed out DURING exercise?
6. Have you passed out or nearly passed out AFTER exercise?
7. Have you had discomfort, pain, or pressure in your chest during exercise?
8. Has your heart raced or skipped beats during exercise?
9. Has a doctor told you that you have a heart murmur, high blood pressure, high cholesterol, or a heart infection?
10. Has a doctor ordered a test for your heart? (for example: ECG, echocardiogram)
11. Has anyone in your family died for no apparent reason?
12. Have you spent the night in a hospital?
13. Have you had surgery?
14. Have you had an injury, like a sprain, muscle or ligament tear, or tendonitis, that required medical attention?
15. Have you had any broken or fractured bones or dislocated joints?
16. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches?

17. Have you had a stress fracture?
18. Did a doctor tell you that you have asthma or allergies?
19. Have you started to cough, wheeze, or have difficulty breathing during or after exercise?
20. Have you used an inhaler or taken asthma medicine?
21. Have you lost a kidney, an eye, a testicle, or any other organ?
22. Do you have any new rashes, pressure sores, or other skin problems?
23. Have you had a new herpes skin infection?
24. Have you had a head injury or concussion?
25. Have you been hit in the head and been confused or lost your memory?
26. Have you had a seizure?
27. Have you experienced headaches with exercise?
28. Have you had numbness, tingling, or weakness in your arms or legs after being hit or falling?
29. Have you been unable to move your arms or legs after being hit or falling?
30. When exercising in the heat, did you have severe muscle cramps or become ill?

Explain "Yes" answers here: ____________________________________________

(continue on front side of this form if necessary)

RECERTIFICATION OF HEALTH

As the parent/guardian, I herewith affix my signature and certify that the above-named student is physically fit to participate in interscholastic athletics for the current school year insofar as all "Yes" responses are concerned.

_____________________________  ________________________________
Date                                 Signature of Parent

Revised 03-18                      PHYS - #2
This is the form that the South Dakota High School Activities Association recommends to those member schools that feel it is important to get consent from parents and/or legal guardians for medical treatment when away from home on road trips for various activities. This form should be kept on file at the school and another copy should travel with each team on which the athlete competes.

CONSENT FOR MEDICAL TREATMENT

I am the PLEASE CIRCLE ONE Mother  Father  Legal Guardian  of__________________________
______________________________, who participates in co-curricular activities for ______
______________________________ High School. I hereby consent to any medical services that may be required while said child is under the supervision of an employee of the ______ School District while on a school-sponsored activity and hereby appoint said employee to act on behalf in securing necessary medical services from any duly licensed medical provider.

Dated this__________________ day of ______________________, 20____

Parent(s)/Legal Guardian Signature:__________________________________________

CONSENT OF CHILD

I, ________________________________, have read the above Consent For Medical Treatment Form signed by my (PLEASE CIRCLE ONE) Mother  Father  Legal Guardian  and join with (PLEASE CIRCLE ONE) him  her  in the consent.

Dated this _______________ day of ______________________________, 20____

Student's Signature:________________________________________________________
SOUTH DAKOTA HIGH SCHOOL ACTIVITIES ASSOCIATION
ANNUAL PARENT AND STUDENT CONSENT FORM

School Year: 2018-2019 Name of High School: ________________________________
Name of Student: ________________________________
Date of Birth: ______________ Place of Birth: ________________________________

The Parent and Student hereby:

1. Understand and agree that participation in SDHSAA sponsored activities is voluntary on the part of the student and is considered a privilege.

2. Understand and agree that (a) by this Consent Form the SDHSAA has provided notification to the parent and student of the existence of potential dangers associated with athletic participation; (b) participation in any athletic activity may involve injury of some type; (c) the severity of such injuries can range from minor cuts, bruises, sprains, and muscle strains to more serious injuries such as injuries to the body’s bones, joints, ligaments, tendons, or muscles. Catastrophic injuries to the head, neck and spinal cord and concussions may also occur. On rare occasions, injuries so severe as to result in total disability, paralysis and death; and (d) even with the best coaching, use of the best protective equipment, and strict observance of rules, injuries are still a possibility.

3. Consent and agree to participation of the student in SDHSAA activities subject to all SDHSAA bylaws and rules interpretations for participation in SDHSAA sponsored activities, and the activities rules of the SDHSAA member school for which the student is participating; and

4. Consent and agree that personally identifiable directory information may be disclosed about the student as a result of his/her participation in SDHSAA sponsored activities. Such directory information may include, but is not limited to, the student’s photograph, name, grade level, height, weight, and participation in officially recognized activities and sports. If I do not wish to have any or all such information disclosed, I must notify the above mentioned high school, in writing, of our refusal to allow disclosure of any or all such information prior to the student’s participation in sponsored activities.

I acknowledge that I have read paragraphs one (1) through four (4) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participating in activities.

DATED this ______ day of ________________________, 20____

________________________________________________________
Name of Student (Print Name) ____________________________ Student Signature ____________________________

I am the student’s parent/guardian. I acknowledge that I have read paragraphs (1) through (4) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participation in athletic activities. I hereby give my permission for __________________________ (student’s name) to practice and compete for the above named high school in activities approved by the SDHSAA.

DATED this ______ day of ________________________, 20____

________________________________________________________
Parent/Guardian (Print Name) ____________________________ Parent/Guardian Signature ____________________________

THIS FORM MUST BE COMPLETED ANNUALLY AND MUST BE AVAILABLE FOR INSPECTION AT THE SCHOOL

Revised 03-18 PHYS - # 4
CONSENT FOR RELEASE OF MEDICAL INFORMATION FORM (HIPAA)

Student Name ___________________________ Date of Birth ___________________________

1. I authorize the use or disclosure of the above-named individual’s health information including the Initial and Interim Pre-Participation History and Physical Exam information pertaining to a student’s ability to participate in South Dakota High School Activities Association sponsored activities. Such disclosure may be made by any Health Care Provider generating or maintaining such information.

2. The information identified above may be used by or disclosed to the school nurse, athletic trainer, coaches, medical providers and other school personnel involved in the care of this student.

3. This information for which I am authorizing disclosure will be used for the purpose of determining the student’s eligibility to participate in extracurricular activities, any limitations on such participation and any treatment needs of the student.

4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the school administration. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

5. This authorization will expire on July 1, 2019.

6. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

7. I understand authorizing the use or disclosure of the information identified above is voluntary. However, a student’s eligibility to participate in extracurricular activities depends on such authorization. I need not sign this form to ensure healthcare treatment.

______________________________  _________________________
Signature of Parent                Date

______________________________  _________________________
Signature of Student (If Over 18)  Date

This form must be completed annually and must be available for inspection at the school

Revised 03-18

PHYS - #5
RETURN TO COMPETITION, PRACTICE, OR TRAINING

This form is to be used after a youth athlete is removed from, and not returned to, competition, practice, or training after exhibiting concussion symptoms. The youth athlete should not be returned to competition, practice, or training until written authorization is obtained from an appropriate health care professional and the parent/guardians. A licensed health care provider is a person who is:
(1) Registered, certified, licensed, or otherwise recognized in law by the State of South Dakota to provide medical treatment; and
(2) Trained and experienced in the evaluation, management, and care of concussions.

This form should be kept on file at the school and need not be forwarded to the SDHSAA Office.

Athlete: ___________________________ School: ___________________________ Grade: ________

Sport: ___________________________ Date of Injury: ___________________________

REASON FOR ATHLETE'S INCAPACITY

Guidelines for returning to competition, practice, or training after a concussion

Note: Each step should be completed with no concussion symptoms before proceeding to the next step.
1. No activity, complete rest with no symptoms.
2. Light exercises: walking or stationary cycling with no symptoms.
3. Sport specific activity without body contact and no symptoms.
4. Practice without body contact and no symptoms. Resume resistance training.
5. Practice with body contact and no symptoms.
6. Return to game play with no symptoms.

Note:
1. If symptoms return at any time during the rehabilitation process, wait until asymptomatic for 1 full day, then re-start at the previous step.
2. Never return to competition with symptoms.
3. Do not use “smelling salts”.
4. When in doubt, sit them out.

HEALTH CARE PROFESSIONAL'S ACTION

I have examined the named student-athlete following this episode and determined the following:

_____ Permission is granted for the athlete to return to competition, practice, or training

_____ Permission is not granted for the athlete to return to competition, practice, or training

COMMENT:

__________________________________________

__________________________________________

__________________________________________

__________________________________________

Date: ____________________

Date: ____________________

Date: ____________________

Health Care Professional

Parent/Guardian

School Administrator

Revised 03-18

PHYS - #6
CONCUSSION FACT SHEET FOR ATHLETES

What is a concussion?
A concussion is a brain injury that:
• Is caused by a bump, blow, or jolt to the head or body
• Can change the way your brain normally works
• Can occur during practices or games in any sport or recreational activity
• Can happen even if you haven’t been knocked out
• Can be serious even if you’ve just been “dinged” or “had your bell rung”

All concussions are serious. A concussion can affect your ability to do schoolwork and other activities (such as playing video games, working on a computer, studying, driving, or exercising). Most people with a concussion get better, but it is important to give your brain time to heal.

What are the symptoms of a concussion?
You can’t see a concussion, but you might notice one or more of the symptoms listed below or that you “don’t feel right” soon after, a few days after, or even weeks after the injury.
• Headache or “pressure” in head
• Nausea or vomiting
• Balance problems or dizziness
• Double or blurry vision
• Bothered by light or noise
• Feeling sluggish, hazy, foggy, or groggy
• Difficulty paying attention
• Memory problems
• Confusion

What should I do if I think I have a concussion?
• Tell your coaches and your parents. Never ignore a bump or blow to the head even if you feel fine. Also, tell your coach right away if you think you have a concussion or if one of your teammates might have a concussion.
• Get a medical check-up. A doctor or other health care professional can tell if you have a concussion and when it is OK to return to play.
• Give yourself time to get better. If you have a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have another concussion. Repeat concussions can increase the time it takes for you to recover and may cause more damage to your brain. It is important to rest and not return to play until you get the OK from your health care professional that you are symptom-free.

How can I prevent a concussion?
Every sport is different, but there are steps you can take to protect yourself.
• Use the proper sports equipment, including personal protective equipment. In order for equipment to protect you, it must be:
  - The right equipment for the game, position, or activity
  - Worn correctly and the correct size and fit
  - Used every time you play or practice
• Follow your coach’s rules for safety and the rules of the sport
• Practice good sportsmanship at all times

It’s better to miss one game than the whole season.

Student’s Name (please print) __________________________________________ Date: __________________
Student’s Signature: __________________________________________ Date: __________________
Parent/Guardian’s Signature: __________________________________________ Date: __________________

THIS FORM MUST BE SIGNED ANNUALLY AND MUST BE AVAILABLE FOR INSPECTION AT THE SCHOOL

Revised 03-18

PHYS - # 7
CONCUSSION FACT SHEET FOR PARENTS

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 or what seems to be a mild bump or blow to the head can be serious.

What are the signs and symptoms?
You can’t 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.

<table>
<thead>
<tr>
<th>Signs Observed By Parents or Guardians</th>
<th>Symptoms Reported by Athlete</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Appears dazed or stunned</td>
<td>• Headache or “pressure” in head</td>
</tr>
<tr>
<td>• Is confused about assignment or position</td>
<td>• Nausea or vomiting</td>
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<tr>
<td>• Forgets an instruction</td>
<td>• Balance problems or dizziness</td>
</tr>
<tr>
<td>• Is unsure of game, score, or opponent</td>
<td>• Double or blurry vision</td>
</tr>
<tr>
<td>• Moves clumsily</td>
<td>• Sensitivity to light or noise</td>
</tr>
<tr>
<td>• Answers questions slowly</td>
<td>• Feeling sluggish, hazy, foggy, or groggy</td>
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<tr>
<td>• Loses consciousness (even briefly)</td>
<td>• Concentration or memory problems</td>
</tr>
<tr>
<td>• Shows mood, behavior, or personality changes</td>
<td>• Confusion</td>
</tr>
<tr>
<td>• Can’t recall events prior to hit or fall</td>
<td>• Just not “feeling right” or is “feeling down”</td>
</tr>
<tr>
<td>• Can’t recall events after hit or fall</td>
<td></td>
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</tbody>
</table>

How can you help your teen prevent a concussion?
Every sport is different, but there are steps your teens 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.

What should you do if you think your teen has a concussion?
1. **Keep your teen out of play.** If your teen has a concussion, her/his brain needs time to heal. Don’t let your teen return to play the day of the injury and until a health care professional, experienced in evaluating for concussion, says your teen is symptom-free and it’s OK to return to play. A repeat concussion that occurs before the brain recovers from the first – usually within a short period of time (hours, days, or weeks) – can slow recovery or increase the likelihood of having long-term problems. In rare cases, repeat concussions can result in edema (brain swelling), permanent brain damage, and even death.

2. **Seek medical attention right away.** A health care professional experienced in evaluating for concussion will be able to decide how serious the concussion is and when it is safe for your teen to return to sports.

3. **Teach your teen that it’s not smart to play with a concussion.** Rest is key after a concussion. Sometimes athletes wrongly believe that it shows strength and courage to play injured. Discourage others from pressuring injured athletes to play. Don’t let your teen convince you that s/he’s “just fine”.

4. **Tell all of your teen’s coaches and the student’s school nurse about ANY concussion.** Coaches, school nurses, and other school staff should know if your teen has ever had a concussion. Your teen may need to limit activities while s/he is recovering from a concussion. Things such as studying, driving, working on a computer, playing video games, or exercising may cause concussion symptoms to reappear or get worse. Talk to your health care professional, as well as your teen’s coaches, school nurse, and teachers. If needed, they can help adjust your teen’s school activities during her/his recovery.

Parent/Guardian’s Name (Please print) ___________________________ Date __________, 20__

Parent/Guardian’s Signature __________________________________________________________________________ Date __________, 20__

THIS FORM MUST BE SIGNED ANNUALLY AND MUST BE AVAILABLE FOR INSPECTION AT THE SCHOOL

Revised 03-18

PHYS - # 8