

**TREMPER SENIOR HIGH SCHOOL**

8560 – 26<sup>th</sup> Avenue  
Kenosha, WI 53143  
262-359-2200

**Tremper Trojan Athletics  
Physical Athletic Forms**

Hello and welcome to the Athletic Department of George Nelson Tremper High School in Kenosha, Wisconsin. If you or someone you know is interested in becoming a member of one of our athletic teams, the following information must be completed in full and returned to the Athletic Department office. Please take the time to read it and all the forms entirely before completing them. I hope that you will find this letter helpful in the process. Thank you.

I. **Emergency Information Card.** This card needs to be completed in full. It accompanies a coach to every away game and serves us with emergency contact information. This card needs to be kept up to date at all times. Should something change, please make these corrections immediately. **This card is required NEW for each and every sport change.** Example: If you complete one in the fall, you will need to do another for the winter season!

II. **Athletic Physical Form.** This is the required form needed for participation in a sport. It needs to be completed in full and requires TWO signatures from the physician. One on the front cover and another on the inside right page of the folder. It also requires THREE parent/guardian signatures. One on the front at the bottom of the cover page, under *Wisconsin Interscholastic Athletic Association-Athletic Permit*. The other two are on the back page, *under Section 2: Athletic Code of Conduct* and the other under *Section 3: Notification of Risk*. All three require the date of the signature as well.

III. **Athletic Code of Conduct.** This form explains the philosophy of athletics within the Kenosha Unified School District #1 and the standards of the Wisconsin Interscholastic Athletic Association. It covers violations of the code, and their consequences, including the appeal process. It is required reading and discussion for both the athletes and their parent/guardians. Failure to read this document will not relieve the infraction nor the consequences imposed upon the athlete. Your signature in Section 3 acknowledges that both you and your athlete have read and agree to comply with the code. The yellow pages themselves should be removed by the athlete and placed with their other valuable school papers for any additional reference.

IV. **\$55.00 Athletic User Fee.** This is the fee associated with participation in the designated seasonal sport. To eliminate refunding, **it is collected only after final cuts have been made, but before the first game, match, or meet has been played!** It too needs to be made in the form of a check (PLEASE), made payable to Tremper Athletics and will be acknowledged with a receipt returned to the student athlete. There is a maximum of \$110 per student and a maximum of \$220 per family per school year.

V. **Permit to Practice.** This is the final step in the registration process and is given directly to the Head Coach of the particular season's sport. It is not given to the athlete! Generally, it includes any receipts that should be given to the athlete acknowledging any fees paid. It signifies that the student athlete has completed all the necessary forms, paid all required fees, and has no outstanding obligations regarding violations of the Code of Conduct.

Should questions arise that I could be of some assistance with, please give me a call at Tremper, 359-2307, and I will try to answer them.

Respectfully,

John Matera  
Athletic Director  
Tremper High School



**SECTION 2: ATHLETIC CODE OF CONDUCT AGREEMENT**

We, the parents/guardians of \_\_\_\_\_, have received, read and understand, and have discussed the Kenosha Unified School District's Athletic Code of Conduct with our son/daughter. We further agree to permit our son/daughter to participate in athletics with the conditions as set forth in the Athletic Code of Conduct. We understand that the Athletic Code of Conduct is in effect for twelve months from the date listed below.

Athlete Signature:   X   \_\_\_\_\_ Date: \_\_\_\_\_

Parent/ Guardian Signature:   X   \_\_\_\_\_ Date: \_\_\_\_\_

**SECTION 3: NOTIFICATION OF RISK OF INJURY**

Participation in any athletic sport carries with it an increased possibility of injury, some of which could be serious and permanent nature, or even death. While coaches will utilize the most current, medically sound conditioning methods and teach only safe, competitive techniques in preparing athletes, the possibility of serious injury still exists. Athletes also have responsibilities to exercise caution and use only approved, safe playing techniques in practice and competition. In addition, all athletes should avail themselves of off-season strength training and conditioning programs available in the schools and community in preparation for their specific sports seasons.

Having been so cautioned and warned about the possible risk of injury in athletic participation, it is still my desire to participate in athletics, and I hereby further acknowledge, with my signature below, that I do so with the full knowledge and understanding of the risk of serious injury to which I am exposed during all athletic participation.

As the parent/guardian of the above athlete I acknowledge, with my signature below, that I fully understand the possibility of the risk of serious injury involved in athletic participation and do hereby grant my son/daughter permission to participate in the sports listed below.

_____	_____	_____
Fall Sport	Winter Sport	Spring Sport
<u>  X  </u> _____	<u>  X  </u> _____	<u>  X  </u> _____
Athlete's Signature	Athlete's Signature	Athlete's Signature
<u>  X  </u> _____	<u>  X  </u> _____	<u>  X  </u> _____
Parent/Guardian Signature	Parent/Guardian Signature	Parent/Guardian Signature
_____	_____	_____
Date	Date	Date

**OFFICE USE ONLY - DO NOT WRITE BELOW THIS LINE**

**SECTION 4: ATHLETIC USER FEE**

The Athletic User Fee is collected to help offset the cost of running the school district's athletic programs and is mandated by Kenosha Unified School Board policy. There is a \$55 fee per sport with a cap of \$110 per athlete per school year, or a cap of \$220 per family per school year. This fee must be paid, but will be refunded if an athlete fails to make a final roster. Fees will not be refunded if an athlete quits the team or is removed for academic or athletic code violations.

Fall Season	Winter Season	Spring Season
[    ] \$55 Paid	[    ] \$55 Paid	[    ] \$55 Paid
OR [    ] \$110 Maximum per individual has been reached	[    ] \$220 Maximum per family has been reached	

Signature: \_\_\_\_\_ Fees Paid: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION  
 COMPREHENSIVE ORTHOPAEDICS, S.C.  
 PRE-SEASON HISTORY & PHYSICAL EXAM – ATHLETIC PERMIT**

**Student's Name:** \_\_\_\_\_ **Grade:** \_\_\_\_\_ **Birth date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Address:** \_\_\_\_\_ **Sex:** \_\_\_\_\_

**Home Telephone:** \_\_\_\_\_ - \_\_\_\_\_ **School:** \_\_\_\_\_ **Student ID#:** \_\_\_\_\_

**Insurance Carrier:** \_\_\_\_\_ **Policy Number:** \_\_\_\_\_

**Insurance Address:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Family Physician:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Family Dentist:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Father's Name:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Father's Place of Employment:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Mother's Place of Employment:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

1. I hereby give my permission for the above named student to practice, compete, and represent the school in WIAA approved interscholastic sports.
2. I further grant permission for any medical records pertaining to the health of the above named student be made available as necessary to the proper school district personnel and appropriate health care providers. This includes allergies and medication, prescribed or over-the-counter.
3. The above named student has my permission to be examined for the purpose of a Pre-Season Sports Screening History and Physical Exam. I understand that this exam is not intended to take the place of regular medical check-ups and that if something is found during this screening exam, further evaluation may be necessary and recommended.
4. All information given in the Health History section of this form is given to the best of our knowledge.

**Signature of Parent/Guardian:**   X   \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

### Health History

	Y	N	If yes, please explain:
1. Any chronic or recurrent illnesses?	_____	_____	_____
2. Any Illnesses lasting more than a week?	_____	_____	_____
3. Are you presently being treated by a doctor for any medical problem?	_____	_____	_____
4. Presently taking any medications?	_____	_____	_____
5. Do you have any allergies?	_____	_____	_____
6. Any hospitalizations?	_____	_____	_____
7. Any surgery?	_____	_____	_____
8. Are any organs missing other than tonsils (e.g. appendix, eye, kidney, testicle, etc.)	_____	_____	_____
9. Are you presently being treated by a doctor for any surgical problems?	_____	_____	_____
10. Any broken (fractured) bones?	_____	_____	_____

	Y	N	If yes, please explain:
11. Any injured joints?	_____	_____	_____
12. Ever been knocked out or had a concussion?	_____	_____	_____
13. Ever had heat exhaustion or stroke?	_____	_____	_____
14. Any difficulty breathing during or after exercise?	_____	_____	_____
15. Do you wear glasses or contact lenses?	_____	_____	_____
16. Do you wear any dental appliances such as braces, bridge, or plate?	_____	_____	_____
17. Date of last tetanus shot.			_____
18. Have any relatives died of heart problems?	_____	_____	_____

If needed, please use this space to further explain any of the above answers or to provide any additional information that may be necessary : \_\_\_\_\_

\_\_\_\_\_

**The section below will be filled in at the time of the exam by the physician. PLEASE DON'T WRITE BELOW**

### Physical Examination

Height: \_\_\_\_\_' \_\_\_\_\_"      Weight: \_\_\_\_\_ lbs.      Resting Pulse: \_\_\_\_\_

Resting Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_ mm Hg

	NL	ABN	Not Exam.	Comments	Examiner
1. HEENT	_____	_____	_____	_____	_____
2. Neck	_____	_____	_____	_____	_____
3. Mouth/Teeth	_____	_____	_____	_____	_____
4. Heart	_____	_____	_____	_____	_____
5. Chest & Lungs	_____	_____	_____	_____	_____
6. Abdomen	_____	_____	_____	_____	_____
7. Skin	_____	_____	_____	_____	_____
8. Pulses	_____	_____	_____	_____	_____
9. Upper extremity	_____	_____	_____	_____	_____
10. Lower extremity	_____	_____	_____	_____	_____
11. Neurological	_____	_____	_____	_____	_____

Additional comments: \_\_\_\_\_

\_\_\_\_\_

### RECOMMENDATIONS

\_\_\_\_\_ There are no apparent contraindications to participation in interscholastic athletic activities.

\_\_\_\_\_ This student should have the following health problems evaluated prior to participation in interscholastic athletic activities.

**Reviewer's Signature:**   X   \_\_\_\_\_ **Date:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

ATHLETIC DEPARTMENT  
KENOSHA UNIFIED SCHOOLS  
**EMERGENCY INFORMATION**

PLEASE PRINT

School: \_\_\_\_\_

Sport: \_\_\_\_\_

Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Parents/Guardian Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Parents Place of Employment (Father) \_\_\_\_\_ Work Phone: \_\_\_\_\_

Parents Place of Employment (Mother) \_\_\_\_\_ Work Phone: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Orthopedic Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Hospital Preferred: \_\_\_\_\_ In an emergency, if parents  
cannot be reached, please notify: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Our family health and accident insurance policy is with \_\_\_\_\_ Company.

The team trainer and coach may apply first-aid treatment until the family physician can be contacted and we further give our consent for coaches, trainers, and team physicians to use their own judgment in securing medical aid and ambulance service in case the parents cannot be reached: YES: \_\_\_\_\_ NO: \_\_\_\_\_

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

Side 2

Player Information: Playing Experience: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Locker No.: \_\_\_\_\_ Combo: \_\_\_\_\_

**INJURY INFORMATION**

Previous Chronic Injuries: \_\_\_\_\_

Operations: \_\_\_\_\_

Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

Dates of Injuries: \_\_\_\_\_

First Aid Treatment Given: \_\_\_\_\_

Diagnosis by Physician: \_\_\_\_\_

Treatment and Rehabilitation Used: \_\_\_\_\_

Date Approved for Practice: (letter or notice from physician required): \_\_\_\_\_