



**Tolland Middle School**  
 One Falcon Way -- Tolland, CT 06084  
 Telephone (860)870-6860 Fax (860) 870-5737

## Welcome to Tolland Middle School Interscholastic Sports Athlete Eligibility

- Students must be in good academic standing and has received less than five (5) detentions and/or two (2) suspensions during the current quarter to participate.
- Students who meet any of the following criteria will have their “good” academic status revoked
  - Average below 65 in two or more subjects (F & F)
  - Average below 65 in one subject (F & D/4 or D/5) and an average between 64 and 70 with an effort rank of 4 or 5 in one or more additional subjects.
  - Average between 64 and 70 with a 4 or 5 effort rank in two or more subjects (D/4 or D/5 and D/4 or D/5)
- Academic standing will be re-evaluated for team members each quarter. A student may reestablish good academic standing at mid-term.

STUDENTS MUST HAVE A PHYSICAL EXAMINATION:

- Dated within one year of the sport they are trying out for.
- The completed physical form must be in the nurse’s office before tryouts
- Parents should be aware that there is no medical personnel present at TMS for tryouts, practice, or games after school hours
- Students requiring inhalers or bee sting medication must have this at all outdoor sports events
- Please share with the coach if there is any physical condition, which would prevent your son/daughter from taking part vigorously and to full capabilities in a competitive activity.

STUDENTS MUST HAVE INSURANCE FOR ATHLETIC ACTIVITIES:

\_\_\_\_\_ is covered by: School Insurance  Private Insurance   
 Students Name

STUDENTS MUST HAVE EMERGENCY CONTACT INFORMATION:

Home: \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

I give consent for \_\_\_\_\_ to participate in \_\_\_\_\_  
 Student activity

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

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Athlete Signature

\_\_\_\_\_  
 Coach Signature





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Congratulations!! We are pleased that you have decided to participate in the Athletic program at Tolland Middle School. Participating in athletics provides you with a special opportunity to receive rewards and recognition and to develop self-pride. To be a successful athlete will require a strong commitment, much personal sacrifice, and self-discipline. We have set high standards for our athletes, as you represent Tolland Middle School both in and out of school. Good luck and much success!

At this time, we would like to thank the parents for their support and for time and patience, it takes on their part for your participation in Tolland Middle School Athletics.

For the purpose of clarity, we are including a copy of the Tolland Middle School rules. Please read and review these rules for participation in our athletic program with the athlete.

### **Tolland Middle School Rules**

1. All eligibility rules will be adhered to and enforced during the season.
2. Smoking, drinking of alcoholic beverages, or use or possession of illegal drugs will result in suspension for the team for the remainder of the season.
3. Team members will exhibit respect for school and personal property. Violations such as school vandalism and theft will result in expulsion from the team for the season
4. Athletes must attend scheduled classes in order to participate in practice or game play on a particular day unless specifically excused by the coach.
5. All athletes must have a physical examination before the first try-out and it must be on file in the nurse's office.
6. All athletes must ride with the team on school-provided transportation to and from all athletic events unless a parental note, approved by the athletic director, is submitted prior to the activity.
7. An athlete suspended from school will not participate in practice or game play for the duration of the suspension.
8. The principal, athletic director and coach must approve special rules particular to a specific sport. These rules must be distributed and discussed with the team at the first team meeting.
9. Situations other than those above will be decided by the principal in consultation with the coach and athletic director.

# Connecticut Pre-participation Sports Evaluation

HISTORY to be filled out by Parent or Student (if over 18)

DATE OF EXAM \_\_\_\_\_

Name _____	Sex _____	Age _____	Date of birth _____
Grade _____	School _____	Sport(s) _____	
Address _____		Phone _____	
Personal physician _____			
<b><i>In case of emergency, contact</i></b>			
Name _____	Relationship _____	Phone (H) _____	(W) _____

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

	Yes	No		Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have an ongoing or chronic illness (Diabetes, Epilepsy, Sickle Cell Disease, Kawasaki's Disease, Marfan's Syndrome or any handicap)?	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear glasses, contacts, or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized overnight?	<input type="checkbox"/>	<input type="checkbox"/>	Do you bruise easily, take a long time to stop bleeding, or have frequent nose bleeds?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had infectious mononucleosis or hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler (for pain or shortness of breath)?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have hearing loss, tubes in your ears, or a perforated eardrum?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever taken any supplements, creatine, steroids, or vitamins to help you gain or lose weight or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have kidney disease or dark brown bloody urine?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have any allergies (for example, to pollen, medicine, food or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have less than 2 kidneys or, in males, less than two testicles?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a rash or hives develop during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have diarrhea more than once a week, or black/bloody bowel movements (stools)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have lump(s) in the armpit or groin?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you ever had a sprain, strain, or swelling after injury?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have you broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	<i>If yes, check appropriate box and explain below:</i>		
Have you had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip
Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh
Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Knee
Have you had a severe viral infection (for example, myocarditis or mononucleosis)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Shin/calf
Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger	<input type="checkbox"/> Ankle
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Upper arm	<input type="checkbox"/> Foot	
7. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	13. Do you want to weigh more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	Have you lost or gained more than 10 pounds in the past year?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	Are you on a special diet?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had numbness or tingling in your arms, hands, legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>	14. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a stinger, burner or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	15. Record the dates of your most recent immunizations (shots) for:		
Have you had a neck, spine or low back injury or pain?	<input type="checkbox"/>	<input type="checkbox"/>	Tetanus _____ Measles _____		
8. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B _____ Chickenpox _____		
9. Do you cough, wheeze, or have trouble breathing during or after activity?	<input type="checkbox"/>	<input type="checkbox"/>	Meningococcus _____		
Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>	<b>FEMALES ONLY</b>		
Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>	16. When was your first menstrual period?		
10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>	When was your most recent menstrual period?		
			How much time do you usually have from the start of one period to the start of another? _____		
			How many periods have you had in the last year? _____		
			What was the longest time between periods in the last year? _____		
			Do you ever require any medication to control menstrual pain? _____		
			If "yes" in the explanation below, include what medication and how much.		
			Explain "Yes" answers here: _____		
			_____		
			_____		
			_____		
			_____		
			_____		

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

Signature of athlete \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

# Connecticut Pre-participation Sports Evaluation

## PHYSICAL EXAMINATION

Name _____		Date of Birth _____	
Height _____	Weight _____	% Body Fat _____	Pulse _____
BP ____/____ ( ____/____, ____/____ )			
Vision: R 20/ _____	L 20/ _____	Corrected: Y N	Pupils: Equal _____ Unequal _____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
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### MEDICAL

Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			

### MUSCULOSKELETAL

Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

\* Station-based examination only

## CLEARANCE

- Cleared
- Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Recommendations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO

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