WAYNE E. BARTELS MIDDLE SCHOOL
PORTAGE, WI 53901

CO-CURRICULAR CODE OF CONDUCT

Dear Parent,

The Portage Community School District believes that co-curricular activities (that is, activities for students which are sponsored by the district but not part of the formal curriculum and not graded) are cooperative endeavors which involve parents as well as the student, coaches, advisors, and administration. This booklet is to help you better understand the school district's expectations in co-curricular activities so we may all work together to make your child's experience in these activities more enjoyable and rewarding. Participation in all such activities is a privilege earned, in part, by accepting and following the regulations contained in this co-curricular code of conduct of the Bartels Middle School.

Students in Bartels Middle School may participate in interscholastic athletics only when a current Wisconsin Interscholastic Athletic Association (W.I.A.A.) physical examination form/parent consent form and a signed co-curricular code form are on file with the school district, and the participation fee has been paid for each sport.

Student misbehavior in school will be dealt with through the ~~*Honor Level Discipline System*~~ Discipline System. ***Any student that reaches ~~Honor Level 3~~ Response Level 2 will be able to practice or rehearse but cannot participate in any contests for 14 calendar days. Any student reaching ~~Honor Level 4~~ Response Level 3 or higher will not be able to practice, rehearse, or participate in any contests for 14 or more calendar days.***

Students are expected to maintain passing grades and have excellent attendance to participate in co-curricular activities. See the full details in the Handbook.

Please have your child return the completed co-curricular form found on the bottom of this page to the middle school office. To avoid disappointment, please see that these are given to the school office before the first day of practice. **Students may not practice or participate until a signed code of conduct and a physical card are on file and the required fees are paid.**

If you have any questions, call Mr. Carlson, Athletic Director of Portage Community Schools, at 742-8545 when school is in session.

Sincerely,

J. Sween, District Administrator, Portage Community Schools

T. Rueth, Wayne E. Bartels Middle School Principal

E. Carlson, Athletic Director for Portage Community Schools

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I have received and read the Co-Curricular Code of Conduct of Bartels Middle School. I understand its provisions and realize that eligibility for participation in co-curricular activities depends upon adherence to it. I agree to adhere to all provisions/expectations of this code.

Student Signature _____ Date_____ Grade_ _

Please Print Student Name_____

Parent Signature _____ Date_____

Please Print Parent Name_____

PARENT & ATHLETE AGREEMENT

Related to Concussion Law WI Stat. 118.293

As a Parent and as an Athlete it is important to recognize the signs, symptoms, and behaviors of concussions. By signing this form you are stating that you understand the importance of recognizing and responding to the signs, symptoms, and behaviors of a concussion or head injury. *This form must be on file for every sports season and every youth athletic organization the athlete is involved with and must be renewed each school year (clubs- every 365 days).*

Parent Agreement:

I _____ have **read** the Parent Concussion and Head Injury Information and **understand** what a concussion is and how it may be caused. I also understand the common signs, symptoms, and behaviors. I agree that my child must be removed from practice/play if a concussion is suspected.

I understand that it is my responsibility to seek medical treatment if a suspected concussion is reported to me.

I understand that my child cannot return to practice/play until providing written clearance from an appropriate health care provider to his/her coach.

I understand the possible consequences of my child returning to practice/play too soon.

Parent/Guardian
Signature_____Date_____

Athlete Agreement:

I_____have **read** the Athlete Concussion and Head Injury Information and **understand** what a concussion is and how it may be caused.

I understand the importance of reporting a suspected concussion to my coaches and my parents/guardian.

I understand that I must be removed from practice/play if a concussion is suspected. I understand that I must provide written clearance from an appropriate health care provider to my coach before returning to practice/play.

I understand the possible consequence of returning to practice/play too soon and that my brain needs time to heal.

Athlete
Signature_____Date_____

WISCONSIN DEPARTMENT OF PUBLIC INSTRUCTION
125 South Webster Street,
PO Box 7841,
Madison, WI 53707-7841
PHONE 608-266-3390
TOLL FREE 800-441-4563
WEB SITE http://www.dpi.wi.gov

Questions and Contact Information

Related to Concussion Law WI Stat. 118.293

Name_____**Date**_____

Address_____

City_____**Zip**_____**County**Columbia

Phone_____**Email**_____

Age_____**School** _____**School District**Portage, Wi

Check all that apply
I participate in:

☐ **Football**	☐ **Baseball/Softball**	☐ **Basketball**	☐ **Hockey**
☐ **Soccer**	☐ **Golf**	☐ **Volleyball**	☐ **Wrestling**
☐ **Track & Field**	☐ **Cross Country**	☐ **Cheerleading**	☐ **Skiing/Snowboarding**
☐ **Gymnastics**	☐ **Tennis**	☐ **Swimming & Diving**	

☐ **Other**_____

Name of Current Team Portage ## Grade Football Team

1. Have you ever had a concussion?_____, if yes, how many?_____

2. Have you ever experienced concussion symptoms?_____Did you report them?_____

Emergency Contacts:

Name: _____ **Relationship:** _____

Phone Number: _____

Name: _____ **Relationship:** _____

Phone Number: _____

Please complete this form and return to the person operating the youth athletic activity.

Portage Warrior Athletics

301 E. Collins Street
Portage, WI 53901

Ed Carlson
Athletic Director
carlsone@portage.k12.wi.us
608-742-8545 ext. 1010

Debra Steiner
Athletic Administrative Assistant
steinerd@portage.k12.wi.us
608-742-8545 ext. 1012

Authorization for Medical Treatment

To be submitted to the Athletic Director: (please print)

_____ _____ _____ _____ _____
Student Grade Age Gender Address

_____ _____
Father (Guardian) Home or Work phone

_____
Cell Phone

_____ _____
Mother (Guardian) Home or Work phone

_____
Cell Phone

_____ ( ) _____
Emergency contact (relationship to student) Contact phone

_____ _____
Physician Physician phone

Medical Information: (list allergies, medications, conditions and any known restrictions).
If you and the Physician of your choice, as indicated above, cannot be reached in an emergency, and if, in the judgment of Portage Community School District coaches, staff, and or officials, find that immediate medical attention and/or hospital attention is indicated do you authorize responsible authorities to send your child, properly accompanied, and to treat your child at an available hospital and/or by a physician?

YES_____☐_____ NO_____☐_____

_____ _____
Parent/Guardian signature Date

This emergency form is valid for the 2020 – 2021 school year.

■ PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, or other): _____

List past and current medical conditions. _____

_____

Have you ever had surgery? If yes, list all past surgical procedures. _____

_____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

_____

_____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

_____

_____

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease?		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
FEMALES ONLY	**Yes**	**No**
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "Yes" answers here.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

1. Consider additional questions on more-sensitive issues.
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

[a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION – ATHLETIC PERMIT CARD

(Print or Type)

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

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

NAME (Last) _____ (First) _____ (Middle Initial) _____ Date of Birth _____

Age _____ Sex assigned at birth (F, M or intersex) _____ Grade _____ School _____ City _____

Present Address _____ Telephone _____

❑ **Medically eligible for all sports without restriction**

❑ **Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of**

_____

_____

❑ **Medically eligible for certain sports**

_____

_____

❑ **Not medically eligible pending further evaluation**

❑ **Not medically eligible for any sports**

Recommendations: _____

_____

_____

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

Name of health care professional (Print/Type) _____

SIGNATURE OF HEALTH CARE PROFESSIONAL (MD OR DO)/PA/APNP*: _____

Clinic Name _____

Address/Clinic _____ City _____ State _____ Zip Code _____

Telephone _____ Date of Examination _____

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

Parents' Place of Employment _____

Family Physician _____ Family Dentist _____

Name of Private Insurance Carrier _____ Telephone _____

Subscriber Member Name (Primary Insured) _____

Emergency Information

Allergies _____

Medications _____

Other Information _____

Immunizations ❑ **Up to date (see attached documentation)** ❑ **Not up to date - specify** _____

(e.g., tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis; pneumococcal; meningococcal; varicella)

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

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____

WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION ALTERNATE YEAR ATHLETIC PERMIT CARD

SCHOOL YEAR 20_____ - 20_____

Physical Date _____

NAME _____ GRADE _____ DATE OF BIRTH _____
Last First Middle Initial

Present Address _____ Telephone _____

Parents' Place of Employment _____

Family Physician _____ Family Dentist _____

Name of Private Insurance Carrier _____ Telephone _____

Subscriber Member Name (Primary Insured) _____

1. I hereby give my permission for the above named student to practice and compete and represent the school in WIAA approved sports.
2. I also attest to the fact that the above named student has had no injury or illness serious enough to warrant a medical evaluation prior to participating this school year.
3. Pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder (collectively known as "HIPAA"), I authorize health care providers of the student named above, including emergency medical personnel and other similarly trained professionals that may be attending an interscholastic event or practice, to disclose/exchange essential medical information regarding the injury and treatment of this student to appropriate school district personnel such as but not limited to: Principal, Athletic Director, Athletic Trainer, Team Physician, Team Coach, Administrative Assistant to the Athletic Director and/or other professional health care providers, for purposes of treatment, emergency care and injury record-keeping.
4. It is recommended that information regarding your child's allergies and prescribed medication be made available.

PARENT: If there is any question that this student may not be qualified for athletic competition without, at least, a partial re-evaluation, contact your medical advisor before signing card.

SIGNATURE OF PARENT _____ DATE _____

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

WIAA Physical Extension Form

The sole purpose of this form is to allow an extension of a student's physical during the Coronavirus pandemic **only if/when the student's local primary care physician is unable to provide a NEW physical** for the student that already has an existing physical on file with the school.

This form is to be completed by the parent of the student-athlete. While the student's physical time period will be extended, it is expected that the student does get a physical by their primary care physician as soon as possible. Under no circumstances will this extension be valid beyond the 2020-21 school year.

To participate on a school-sponsored interscholastic athletic team or squad, a student 1) whose physical examination was completed, 2) whose physical is on file with the school, and 3) whose local primary care physician is unable to provide a new physical, must submit this form to the school. This health history update questionnaire must be completed and signed by the student's parent or guardian for review by the school athletic director and/or school nurse.

Any student who does not have an existing physical on file with the school will require a physical with their primary care physician before participating in practice and competition. (ie: freshman who did not have a middle school physical or senior who did not have a physical since freshman year). This form is not to be used for those students.

HEALTH HISTORY UPDATE QUESTIONNAIRE

Name of School _____

To participate on a school-sponsored interscholastic athletic team or squad, a student whose physical examination was completed within the last two years, and whose local primary care physician is unable to provide a new physical, must submit this form to the school. This health history update questionnaire must be completed and signed by the student's parent or guardian.

Student _____ **Age**_____ **Grade** _____

Date of Last Physical Examination_____ **Sport**_____

Since the last pre-participation physical examination, has your son/daughter:

1. Had any changes in health since the last physical? Yes ___ No ___
2. Had a positive lab test for COVID-19 or been hospitalized with presumed COVID-19? Yes ___ No ___
3. Been medically advised not to participate in a sport? Yes____ No____

   If yes, describe in detail _____

_____

_____

4. Sustained a concussion, been unconscious or lost memory from a blow to the head? Yes____ No____

   If yes, explain in detail _____

_____

_____

5. Broken a bone or sprained/strained/dislocated any muscle or joints? Yes____ No____

   If yes, describe in detail _____

_____

_____

6. Fainted or "blacked out?" Yes____ No____

   If yes, was this during or immediately after exercise? _____

_____

_____

7. Experienced chest pains, shortness of breath or "racing heart?" Yes____ No____

   If yes, explain _____

_____

8. Has there been a recent history of fatigue and unusual tiredness? Yes____ No____
9. Been hospitalized or visited the emergency room? Yes____ No____

   If yes, explain in detail _____

_____

_____

10. Since the last physical examination, has there been a sudden death in the family or has any member of the family under age 50 had a heart attack or "heart trouble?" Yes____ No____
11. Started or stopped taking any over-the-counter or prescribed medications that your primary care provider is not aware of? Yes____ No____

    If yes, name of medication(s)_____

_____

Date: _____ **Signature of parent/guardian** _____

PLEASE RETURN COMPLETED FORM TO THE SCHOOL ATHLETIC DIRECTOR