Hello,

We are reaching out on behalf of the nurses here in Indianapolis. Ms. Kelly Hall, our regional nurse over the Indianapolis area, is looking to add medical and physical documentation to our websites for families. Attached you find documentation in which she would like added for each school under a **"Health Services"** tab. Under the health services tab, she would like a drop down for two documents, medical forms and a separate one for sports physicals. Next, for each website, she would like the nurses at each location to have contact information so families can reach them directly via phone call.

Here are the names of the links that go with each document. I have put them in order that you have received them:

Immunizations Required 2026-2027
School Protocol on illness (Indiana Department of Education)
First Aid/Emergency Medical Care Consent
Request to Administer Medication
Medical Condition list
Administration of Medication policy
Food Allergy Action Plan
Asthma Action Plan
Seizure Action Plan
Diabetes Action Plan
Vaccine Medical Exemption
Vaccine Religious Exemption
ISHAA Sports Physical

We would also like the Nurse's info on each website: See below:

GVP
Nurse - Ms. Hall - 317-333-6980

PLA 48
Nurse - Ms. Hall -317-226-4248

PLA 93
Nurse - Ms. Webster - 317-226-4293

PLA 103
Nurse - Ms Gearries - 317-226-4103

JRP
Nurse - Ms. Brownie - 317-552-1600

Required and Recommended School Immunizations, Indiana 2026-2027 (Proposed)

Grade	Required		Recommended
Pre-K	3 Hepatitis B 4 DTaP (Diphtheria, Tetanus and Pertussis) 3 Polio	1 Varicella (Chickenpox) 1 MMR (Measles, Mumps and Rubella) 2 Hepatitis A	Haemophilus influenza B Pneumococcal conjugate Annual influenza COVID-19
K-5	3 Hepatitis B 5 DTaP 4 Polio	2 Varicella 2 MMR 2 Hepatitis A	Annual influenza COVID-19
6-11	3 Hepatitis B 5 DTaP 4 Polio 2 Varicella	2 MMR 2 Hepatitis A 1 MCV4 (Meningococcal) 1 Tdap (Tetanus, Diphtheria and Pertussis)	Annual influenza 2 or 3 HPV (Human papillomavirus) COVID-19
12	3 Hepatitis B 5 DTaP 4 Polio 2 Varicella	2 MMR 2 Hepatitis A 2 MCV4 1 Tdap	Annual influenza 2 or 3 HPV 2 MenB (Meningococcal) COVID-19

HepB: The minimu
Hepatitis B is 24 we

DTaP: Four doses c
fourth dose was ad
birthday.

Polio*: Three dose
grade levels if the t
fourth birthday anc
previous dose.
*For students in gra
administered on or
administered at lea
dose.

Varicella: Physician
including month ar
children entering p
report of disease h

Tdap: There is no r
dose.

MCV4: Individuals
after their 16th birtl

Hepatitis A: The n
second dose is six
required for all gra

For additional immunization information, visit: **in.gov/health/immunization**
or call **1 (800) 701-0704** during normal business hours.

School Immunizations for 2026.27:

Grades K-5 Required:

- **3 Hepatitis B**
- **5 DTaP**
- **4 Polio**
- **2 Varicella**
- **2 MMR**
- **2 Hepatitis A**

Recommended: Annual influenza and COVID-19

Grades 6-11 Required:

- **3 Hepatitis B**
- **5 DTaP**
- **4 Polio**
- **2 Varicella**
- **2 MMR**
- **2 Hepatitis A**
- **1 MCV4 (Meningococcal)**
- **1 Tdap (Tetanus, Diphtheria and Pertussis)**

Recommended: Annual influenza, 2 or 3 HPV (Human papillomavirus), and COVID-19

Grade 12 Required:

- **3 Hepatitis B**
- **5 DTaP**
- **4 Polio**
- **2 Varicella**
- **2 MMR**
- **2 Hepatitis A**
- **2 MCV4**
- **1 Tdap**

Recommended: Annual influenza, 2 or 3 HPV, 2 MenB (Meningococcal), and COVID-19

HepB: The minimum age for the third dose of Hepatitis B is 24 weeks of age.

DTaP: Four doses of DTaP/DTP/DT are acceptable if fourth dose was administered on or after the fourth birthday.

Polio*: Three doses of Polio are acceptable for all grade levels if the third dose was given on or after the fourth birthday and at least six months after the previous dose. *For students in grades K-12, the final dose must be administered on or after the fourth birthday and be administered at least six months after the previous dose.

Varicella: Physician documentation of disease history, including month and year, is proof of immunity for children entering preschool through 12th grade. Parent report of disease history is not acceptable.

Tdap: There is no minimum interval from the last Td dose.

MCV4: Individuals who receive their first dose on or after their 16th birthday only need one dose of MCV4. Hepatitis A: The minimum interval between first and second dose is six calendar months. Two doses are required for all grade levels.

Updated 2/2026

How Sick is too Sick?

This information sheet is designed to be used as a general guidance for parents. If parents have medical questions, they are encouraged to consult with a healthcare provider.

Symptom	Send to School	Keep at Home
Fever	During the past 24 hours, the student's temperature has been below 100.4 degrees and no fever-reducing medication has been taken.	During the past 24 hours, the student's temperature has been more than 100.4 degrees.
Diarrhea	During the past 24 hours, no more than one watery stool has occurred.	During the past 24 hours, more than one watery stool has occurred.
Vomiting	During the past 24 hours, no vomiting has occurred.	During the past 24 hours, vomiting has occurred.
Eye Irritation	Eyes may be itchy, but are not red, crusty, or draining.	Eyes are pink, draining, crusty, itching, painful, sensitive to light, or student has vision changes.
Cough/Runny Nose	Slight cough or runny nose, but no fever, and the student is able to cover cough, blow nose, and wash hands.	Symptoms are severe enough that the student is unable to learn. The student has a fever, or is unable to cover cough, blow nose, or wash hands.
Rash	Rash is not draining or spreading. The student does not have a fever, and symptoms of itching are not severe enough to impede learning.	Rash is bothersome and distracting. The student has a fever or severe itching, or rash is spreading or draining.
Asthma	Symptoms are well controlled, and the student knows when to contact a school adult for assistance or the student has an asthma action plan on file at the school and is following the plan.	Symptoms are not well controlled. The student is not able to recognize when he/she needs assistance, and no asthma action plan is on file at the school.

Updated 6-20-22

FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM

Child's Name_____ Date of Birth_____

I authorize staff at Phalen Leadership Academy 48 who are trained in the basics of first aid to give my child first aid when appropriate.

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the program to transport my child to the nearest medical facility and/or to_____, and to secure necessary medical treatment for my child.

Child's Physician Name:_____
Address:_____
Phone Number:_____

Child's Allergies:_____
Chronic Health Conditions:_____

EMERGENCY CONTACTS (in order to be contacted)

Name:_____ Address:_____

Relationship to Child:_____ Phone #:_____

Do you give permission for child to be released to this person? Yes_____ No_____

Name:_____ Address:_____

Relationship to Child:_____ Phone #:_____

Do you give permission for child to be released to this person? Yes_____ No_____

Name:_____ Address:_____

Relationship to Child:_____ Phone #:_____

Do you give permission for child to be released to this person? Yes_____ No_____

Health Insurance Coverage:_____ Policy#_____

Parent(s) Name_____ Phone(work)_____
Phone(home)_____

Parent(s) Name_____ Phone(work)_____
Phone(home)_____

_____ _____
Parent/Guardian Signature **Date**

REQUEST TO ADMINISTER MEDICATION 2025-2026

If your child is needing to take medication (prescription/non prescription) during the school day, the parent/guardian must complete this request form and turn it in to Ms. Hall or Ms. Wallace. If the medication is prescribed by a Physician, you must provide a written prescription from the child's physician or the current pharmacy label with the request. A physician's order is also necessary for prescription samples that may have been provided to the student, or for any over the counter medication that is NOT recommended for children under the age of 12.

PARENT/GUARDIAN AUTHORIZATION

I request that the medication described below be administered to my child at the times specified during the school day. I will give the nurse the medication in its original container or current prescription bottle.

I understand that a parent/guardian will transport all medication to and from Phalen Academy 48. MEDICATIONS MUST BE PICKED UP BY THE LAST DAY OF SCHOOL, OR MEDICATIONS WILL BE DISCARDED.

I understand that a separate form must be completed for each medication. This request is in effect for one school year and must be renewed annually or whenever there is a change in medication.

I understand that this medication will be administered to my child only by authorized staff members and will be kept in a secure location within the school nurse clinic.

_____ _____ _____
Student's Name (Please print) Grade Teacher

_____ _____ _____
Name of medication Prescribed Over-the-counter

_____ _____am _____pm
Amount of medication to be given Time(s) to administer

_____ _____
Amount of medication to be given Reason for medication

_____ _____
Signature of Parent/Guardian Date

_____ _____
Printed Name Primary phone#/Secondary phone#

MEDICAL CONDITION ALERT

STUDENT'S NAME: _____ **SCHOOL YEAR:** _____

GRADE: _____ **TEACHER:** _____ **BUS#** _____

ADDRESS: _____

MEDICAL AND/OR ALLERGY CONDITION(S):

1.) _____
2.) _____
3.) _____
4.) _____

SYMPTOMS: (what to look for regarding his/her condition)

1.) _____

2.) _____

CURRENT MEDICATIONS (Taken at home or at school:)

1.) _____ 2.) _____

3.) _____ 4.) _____

SPECIFIC INSTRUCTIONS: (If problem occurs with his condition)

1.) _____

2.) _____

A separate MEDICATION PERMISSION FORM signed by a parent/guardian is REQUIRED for all medications given at school

PARENT/GUARDIAN'S SIGNATURE: _____ **DATE:** _____

PARENT/GUARDIAN'S HOME/CELL: _____

CALL 2nd: NAME: _____ **CELL:** _____

PHYSICIAN'S PHONE NUMBER: _____

By signing this form, I agree to allow this information to be shared with any and all school personnel who may be in contact with my child.

Staff Use Only: _____ **Scanned to Staff:** _____ **Entered in PowerSchool:** _____ **CML:** _____

ADMINISTRATION OF MEDICATION POLICY

The purpose of administering medication in school is to help each student maintain an optimal state of health to enhance his educational plans. MEDICATIONS SHOULD BE GIVEN AT HOME WHENEVER POSSIBLE. Medications given during school hours should be only those necessary to provide the student access to his/her educational program. The intent of the guidelines is to reduce the number of medications given at school, yet assume safe, effective administration of medications for those students who require them.

Each school corporation should establish a written policy consistent with the Indiana Law IC 34-4-16.5-3.5 of the Indiana Tort Claims Act, effective March 2, 1988 (see page 106), 511 IAC 7-1-2(k), and Indiana Legend Drugs, IC 6-6-8-2. The guidelines provided assist with the interpretation of the law and can be incorporated into your school corporation policy:

1.) **Only those medications which are necessary to maintain the child in school and must be given during school hours shall be administered.**
2.) **A program for administration of medications is developed and managed by the School Nurse.**
   a.) **Written instructions such as a medication authorization form is signed and completed by the physician and/or parent of the student who is to receive medication.**
   b.) **Medications prescribed for a student (legend drugs) are kept in the original container/package with pharmacy label and Student's name affixed. The pharmacy label can serve as the written order of a Practitioner.**
   c.) **All medications are kept in locked areas or in tamper proof containers.**
   d.) **When a medication is to be administered at school, the school nurse will know the purpose of the medication, side effects, dosage, administration route and time. This information is discussed with the student and other staff assigned to administer medication.**
   e.) **Effectiveness and side effects shall be assessed with each administration and documented as necessary. Documentation of effects for long-term medication should be summarized and written feedback provided to the licensed prescriber and parent(s)/guardian at appropriate intervals.**
   f.) **All permission for long-term medication shall be renewed at least annually. Changes in medication shall be documented by written authorization from a licensed prescriber.**

- **All medication must be brought to school by a parent/guardian, or an adult, age 18 and over, who is on the students contact list in PowerSchool.**
- **Medication brought to school by a student will NOT be given and a parent/guardian must come to the school to retrieve the medication.**
- **Medication MUST be brought to the Nurse's office in a new, sealed, unopened container.**
- **Medication will not be returned home with students. A parent/guardian or an adult, age 18 and over, who is on the student's emergency contact list in PowerSchool, must pick up the medication from the Nurse's Office.**
- **Medication not picked up by the end of the day on the last day of school will be destroyed. Expired medications will also be destroyed. In the event a mediation is discontinued, the medication must be picked up by the parent/guardian within five school days or the medication will be destroyed.**
- **This form is valid for the current school year only.**
- **A new form is required for any changes in medication, dose or administration time.**
- **The Nurse/Health Assistant must be notified in writing when a medication is to be discontinued.**
- **Personnel administering medication are trained on safe medication administration practices on an annual basis. These trained but unlicensed personnel will most likely give medication. A list of trained personnel is on file with the Director of Health Services.**
- **Medications can be administered up to 60 minutes prior to or 60 minutes after the scheduled administration time prescribed by the health care provider. Health assistants will make a good faith effort to administer medication as scheduled. Should your student arrive at the Nurse's Office outside of this time period, the dose will not be given. Some families find that a wristwatch with an alarm helps remind students to go to the nurse's office for their medication.**
- **Medication stored in the clinic is only available to the student during the regular school day.**
- **In the event of a two-hour delay, medications will be given at the prescribed time. Doses will not be rescheduled.**
- **No over the counter medication will be given before noon.**

OVER THE COUNTER MEDICATIONS (OTC)

OTC (non-prescription) medications may be given at school. The school nurse must be aware of the purpose for which a student is to receive the medication. **OTC shall be brought in with the manufacturer's original label with the ingredients listed and the student's name affixed to the NEW UNOPENED package.** ***If your child is under the age of 12 then the dose of the OTC medication needs to be Junior Strength.***

****Antibiotics that are to be given 3 times a day should be given at home, before school, after school and at bedtime****

UPDATED 5/23

FARE FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLA

Food Allergy Research & Education

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

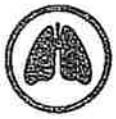
THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS



LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

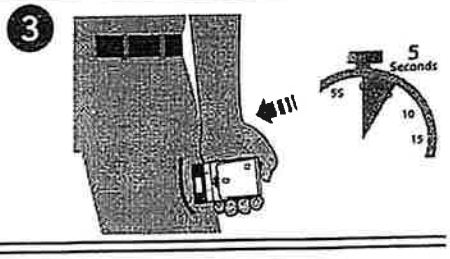
PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE

PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FARE Food Allergy Research & Education

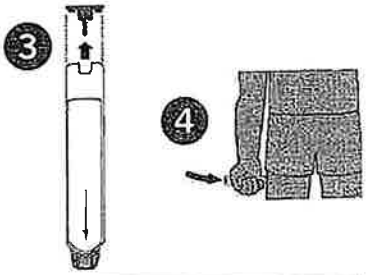
FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLA

HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO



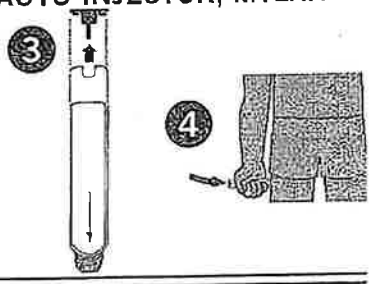
1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly, and hold in place for 5 seconds.
5. Call 911 and get emergency medical help right away.

HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR, MYLAN



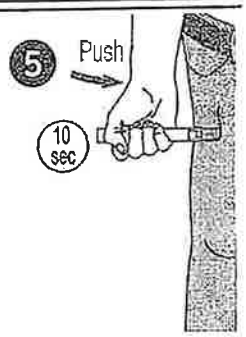
1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.

HOW TO USE EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN



1. Remove the epinephrine auto-injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.

HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES



1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

ASTHMA MANAGEMENT PLAN & AUTHORIZATION FOR MEDICATION

TO BE COMPLETED BY PARENT:

Patient's Name _____ Date of Birth _____ School _____ Grade_____

❒ School E-mail _____ ❒ School Fax (___) _____

Parent/Caregiver _____ Phone (H) _____ Phone (W) _____

Phone (Cell) _____ E-mail _____

Emergency Contact _____ Relationship _____ Phone _____

Asthma Care Provider _____ ❒ Office Phone (___) _____

❒ Office E-mail _____ ❒ Office Fax (___) _____ (please mark best contact)

TO BE COMPLETED BY ASTHMA CARE PROVIDER

RESCUE (quick-relief) MEDICATION: _____

MONITORING	TREATMENT
RED **RED ZONE: DANGER SIGNS** • Very short of breath, or • Rescue medicines have not helped, or • Cannot do usual activities, or • Symptoms are same or get worse after 24 hours in Yellow Zone **RED ZONE: EMERGENCY SIGNS** • Lips and fingernails are blue or gray • Trouble walking and talking due to shortness of breath • Loss of consciousness	• Give rescue medication: ❒ 2 ❒ 4 ❒ 6 puffs (1 min between puffs) or 1 nebulizer treatment • **Call parent and/or Asthma Care Provider** • **Call 911 NOW if:** 1. Unable to reach medical care provider after arriving in the red zone 2. Child is struggling to breathe and there is no improvement after taking albuterol 3. May repeat rescue medication every 10 minutes if symptoms do not improve, until medical assistance has arrived or you are at the emergency department
YELLOW **YELLOW ZONE: CAUTION** • Cough, wheeze, chest tightness, or shortness of breath, or • Waking at night due to asthma, or • Can do some, but not all, usual activities	• Continue daily controller medications • Give rescue medication: ❒ 2 ❒ 4 ❒ 6 puffs (1 min between puffs) OR 1 nebulizer treatment every 4 hours as needed • Wait 10 minutes and recheck symptoms • **If not better, go to RED ZONE** • **If symptoms improve, may return to class or normal activity, or** _____ • **Parent/School Nurse:** If needed, coordinate rescue medications to be given every 4 hours for ❒ 2 ❒ 3 days, if symptoms remain improved • If symptoms are not gone after ❒ 2 ❒ 3 days, move to the **RED ZONE**
GREEN **GREEN ZONE: WELL** • No cough, wheeze, chest tightness, or shortness of breath during the day or night • Can do usual activities	

MEDICATION	HOW MUCH	WHEN
		Before Exercise ❒ Recess ❒ PE/Sports *(not to exceed every 4 hours)*
DAILY CONTROLLER MEDICATION	**HOW MUCH**	**WHEN**

❒ Administer medications as instructed above

❒ Student has been instructed in the proper use of all his/her asthma medications, and in my opinion, the student can carry and use his/her inhaler at school

❒ Student needs supervision or assistance to use his/her inhaler medication

❒ Student should NOT carry his/her inhaler while at school ❒ Have student use spacer with inhaler medication

_____ _____ _____

ASTHMA CARE PROVIDER SIGNATURE **PLEASE PRINT PROVIDER NAME** **DATE**

I give permission for the school nurse and any pertinent staff caring for my child to follow this plan, administer medication and care for my child, contact my asthma care provider if necessary and for this form to be faxed/emailed to my child's school or be shared with school staff per FERPA guidelines. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices.

_____ _____

PARENT SIGNATURE **DATE**

EPILEPSY FOUNDATION
Not another moment lost to seizures

Seizure Action Plan

Effective Date

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

Student's Name | Date of Birth

Parent/Guardian | Phone | Cell

Other Emergency Contact | Phone | Cell

Treating Physician | Phone

Significant Medical History

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Student's response after a seizure:

Basic First Aid: Care & Comfort

Please describe basic first aid procedures:

Does student need to leave the classroom after a seizure? ☐ Yes ☐ No

If YES, describe process for returning student to classroom:

Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

For tonic-clonic seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

Emergency Response

A "seizure emergency" for this student is defined as:

Seizure Emergency Protocol
(Check all that apply and clarify below)

- ☐ Contact school nurse at _____
- ☐ Call 911 for transport to _____
- ☐ Notify parent or emergency contact
- ☐ Administer emergency medications as indicated below
- ☐ Notify doctor
- ☐ Other _____

A seizure is generally considered an emergency when

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

Treatment Protocol During School Hours (include daily and emergency medications)

Emerg. Med. ✓	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a **Vagus Nerve Stimulator?** ☐ Yes ☐ No If YES, describe magnet use:

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions:

Physician Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

School Nurse

SCHOOL INTAKE INTERVIEW - DIABETES

Student _____ Date of Birth _____

School _____ Grade _____ Homeroom Teacher _____

Parent(s)/Guardian(s) _____

Phone (H) _____ (W) _____ (Other) _____

Emergency contact (other than parent/guardian) _____ Phone

Physician Name _____ Office Phone _____ Fax _____

Diabetes Nurse Educator's Name _____ Office Phone _____

Medical release of information signed? Yes _____ No _____

Mode of transportation to and from school? _____ Bus driver notified of diabetes? Yes _____ No _____

Does child participate in after school activities? Yes _____ No _____ Before _____ Or after _____ Care?

Explain _____

Adult leader notified of diabetes? Yes _____ No _____

Field trip recommendations: _____

Blood Sugar Monitoring:

Test will be performed in _____ (location).

Needs assistance with testing? Yes _____ No _____ Explain _____

Required test times _____

Call parent if blood sugar is below _____ Or above _____

Staff to record values and report to parents daily _____ weekly _____

Comments: _____

Continuous Glucose Monitoring: Model: Alarm parameters:

Meds: **Insulin:** Can child give own injections? Yes _____ No _____ Explain _____

Order for insulin on file? Yes _____ No _____

Time(s) insulin to be administered at school: _____

Type/Dosages: _____

Form of administration: _____

(Injection, Pen, Pump)

Oral medications: Type _____ Times _____ Dose _____

Comments: _____

Diet: Assigned student lunch time(s)? _____

Is child following a prescribed meal plan? Yes ___ No ___ Assistance required? Yes ___ No ___

Explain _____

Snack Time(s)? _____ Assistance required? Yes ___ No ___

Explain _____

Snack will be eaten in _____ (location)

Snacks will be stored in _____ (location)

Recommended snacks _____

Parent wishes to be notified in advance of class parties? Yes _____ No _____

Child may partake in class treats? Yes _____ No _____ Explain _____

Comments: _____

Physical Education:

Scheduled at: _____

Is snack necessary before physical education? Yes _____ No _____

Does child participate in after school sports? Yes _____ No _____

P.E. Teacher/Coach aware of child's diabetes? Yes _____ No _____

Comments: _____

Student: _____ DOB: _____ Date of Plan: _____

Supplies to be Provided by Parent/Guardian: Parents/Guardian and student are responsible for maintaining necessary supplies, snacks, blood glucose meter, medications and other equipment.

General Supplies:

Insulin Supply (Pen, Vial)	☐ Needed	☐ Provided	☐ Not Needed
Insulin Syringes/needles	☐ Needed	☐ Provided	☐ Not Needed
Oral Medication	☐ Needed	☐ Provided	☐ Not Needed
Blood glucose meter and glucose strips	☐ Needed	☐ Provided	☐ Not Needed
Lancets with lancing device	☐ Needed	☐ Provided	☐ Not Needed
Blood ketone monitor/strips	☐ Needed	☐ Provided	☐ Not Needed
Urine ketone strips	☐ Needed	☐ Provided	☐ Not Needed
Antibacterial skin cleaner or alcohol wipes	☐ Needed	☐ Provided	☐ Not Needed
Fast Acting Sugar: (e.g. Glucose tabs, juice, Smartees)	☐ Needed	☐ Provided	☐ Not Needed
Glucose Gel/Cake Mate	☐ Needed	☐ Provided	☐ Not Needed
Carbohydrate/Protein snack	☐ Needed	☐ Provided	☐ Not Needed
Glucagon Emergency Kit®	☐ Needed	☐ Provided	☐ Not Needed
Other: _____			

Pump Supplies:

Insulin Pump	☐ Needed	☐ Provided	☐ Not Needed
Insulin Pump Batteries	☐ Needed	☐ Provided	☐ Not Needed
Insulin Pump Cartridge	☐ Needed	☐ Provided	☐ Not Needed
Infusion Set	☐ Needed	☐ Provided	☐ Not Needed
Quick-seter/Sof-sert/Sil-serter	☐ Needed	☐ Provided	☐ Not Needed
Dressings/tape	☐ Needed	☐ Provided	☐ Not Needed
Manufacturer Instructions	☐ Needed	☐ Provided	☐ Not Needed
Batteries	☐ Needed	☐ Provided	☐ Not Needed
Other _			

Pods for OMNI POD			
Manufacturer Instructions	☐ Needed	☐ Provided	☐ Not Needed
Continuous Glucose Monitor	☐ Needed	☐ Provided	☐ Not Needed
	☐ Needed	☐ Provided	☐ Not Needed

Disaster Supplies: Parents determination (insulin/supplies for 72 hours) ☐ Needed ☐ Provided ☐ Not Needed

Supplies Location:

Location of hypoglycemia supplies: _____

Location of other supplies & equipment: _____

☐ Student Self Carries/Supplies are kept: _____

Supplies provided for:

☐ Extracurricular Activities

☐ Before and After School Programs

☐ Other: ____

Notification of needed supplies to Parents/Guardians by: ☐ EMAIL ☐ Telephone ☐ Text ☐ Note home

Parent: _____ Parent Signature: _____ Date: _____

School Nurse: _____ School Nurse Signature: _____ Date: _____

VACCINE MEDICAL EXEMPTION

State Form 54648 (4-11)
Indiana State Department of Health, Immunization Division

INSTRUCTIONS: *1. This form for any child in grades K – 12 who is unable to receive a vaccine required for school entry due to a medical contraindication.*
2. Complete and sign form. Submitted to school as proof of exemption from required immunization.

Patient Name _____ Date of Birth *(month/day/year)* _____

Parent/Guardian Name _____ Relationship _____

Street Address _____

City _____ ZIP Code _____ Telephone Number _____

General Contraindications to All Vaccines (*Vaccine should **not** be given.*)

Severe allergic reaction (e.g., anaphylaxis) after a previous vaccine dose or to a vaccine component

- ☐ Hepatitis B (Hep B)
- ☐ Diphtheria, tetanus, pertussis (DTaP, Tdap)
- ☐ Tetanus, diphtheria (DT, Td)
- ☐ Inactivated poliovirus (IPV)
- ☐ Measles, mumps, rubella (MMR)
- ☐ Varicella (Var)
- ☐ Meningococcal, conjugate (MCV4) or Meningococcal, polysaccharide (MPSV4)

Which vaccine or vaccine component caused reaction? _____

Type of Clinical Reaction & Date *(month, day year)* _____

Vaccine Specific Contraindications (Vaccine should **not** be given.)

DTaP or Tdap	☐ Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures) not attributable to another identifiable cause within seven (7) days of administration of previous dose of DTP or DTaP
MMR	☐ Pregnancy Estimated Date of Confinement (EDC): _____ *(month, day year)* ☐ Known severe immunodeficiency (e.g., hematologic and solid tumors; receiving chemotherapy; congenital immunodeficiency; long term immunosuppressive therapy; or patients with HIV infection who are severely immunocompromised)
Varicella	☐ Pregnancy Estimated Date of Confinement (EDC): _____ *(month, day year)* ☐ Substantial suppression of cellular immunity

Vaccine Specific Precautions (*Vaccine may be given or held depending on clinical situation.*)

DTaP or Tdap	☐ Guillan-Barre syndrome (GBS) within six (6) weeks after a previous dose of tetanus-containing vaccine ☐ History of Arthus-type hypersensitivity reaction following a previous dose of tetanus and/or diphtheria toxoid-containing vaccine: defer vaccination until at least ten (10) years have elapsed since the previous dose ☐ Progressive or unstable neurologic disorder, uncontrolled seizures or progressive encephalopathy: defer vaccination with DTaP or Tdap until a treatment regiment has been established and the condition has stabilized
DTaP	☐ Temperature of ≥105F (≥40.5C) within forty-eight (48) hours after vaccination with a previous dose of DTP/DTaP ☐ Collapse and shock-like state (i.e.: hypotonic hyporesponsive episode) within forty-eight (48) hours after previous dose of DTP/DTaP ☐ Seizure or convulsion within three (3) days after receiving a previous dose of DTP/DTaP ☐ Persistent, inconsolable crying lasting three (3) or more hours within forty-eight (48) hours after a previous dose of DTP/DTaP
MMR	☐ Recent (within eleven (11) months) receipt of antibody-containing blood product (interval depends on product) ☐ History of thrombocytopenia or thrombocytopenic purpura
Varicella	☐ Recent (within eleven (11) months) receipt of antibody-containing blood product (interval depends on product) ☐ Receipt of specific antivirals (i.e., acyclovir, famciclovir, or valacyclovir) twenty-four (24) hours before vaccination; if possible, delay resumption of these antiviral drugs for fourteen (14) days after vaccination

Other Medical Contraindication (*Must list vaccine(s) and contraindications individually – continue on back if necessary.*)

Vaccine	Specific Contraindication

Please indicate the duration of the medical exemption, and if and when vaccine can be safely administered.
(Exemption can last for a maximum of one (1) year, and a new form must be completed annually if medical exemption still applies.)

- ☐ Medical exemption is permanent, and will apply for one (1) year from today's date.
- ☐ Medical exemption is temporary (<1 year), and resolution is anticipated by ____/____/____
- ☐ Medical exemption is pregnancy, and Estimated Date of Confinement (EDC) is ____/____/____

Physician Name _____ Physician License Number _____

Office Address _____ Telephone _____

Physician Signature _____ Date *(month, day year)* _____

STATEMENT OF IMMUNIZATION HISTORY; WAIVER; RULES - INDIANA CODE §20-34-4-5

(a) Each school shall require the parent of a student who has enrolled in the school to furnish **not later than the first day of school** a written statement of the student's immunization, accompanied by the physician's certificates or other documentation, unless a written statement of this nature is on file with the school.
(b) The statement must show, except for a student to whom IC 20-34-3-2 or IC 20-34-3-3 applies, that the student has been immunized as required under section 2 of this chapter. The statement must include the student's date of birth and the date of each immunization.

VACCINATION EXEMPTION PURSUANT TO INDIANA CODE §20-34-3-2

(a) Except as otherwise provided, a student may not be required to undergo any testing, examination, immunization, or treatment required under this chapter or IC 20-34-4 when the child's parent objects on religious grounds. A religious objection does not exempt a child from any testing, examination, immunization, or treatment required under this chapter or IC 20-34-4 unless the objection is:
(1) made in writing;
(2) signed by the child's parent; and
(3) delivered to the child's teacher or to the individual who might order a test, an exam, an immunization, or a treatment absent the objection.

VACCINE EXEMPTION FORM

I,_____, as the parent, guardian or person in
(insert your name)
loco parentis of the child _____, hereby certify that the
(insert your child's name)
administration of any vaccine or other immunizing agents is contrary to our personal religious beliefs.

- ☐ Tetanus
- ☐ Diphtheria
- ☐ Pertussis
- ☐ Polio
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Meningitis
- ☐ Measles
- ☐ Mumps
- ☐ Rubella
- ☐ Varicella
- ☐ Haemophilus influenzae type b
- ☐ Other _____

This is pursuant to my right to refuse vaccination on the grounds that vaccinations conflict with my religious beliefs. Pursuant to Indiana statute I am providing a copy of this statement to our child's school administrator or operator of the group program pursuant to IC § 20-34-3-2.

Parent _____ Date _____

PREPARTICIPATION PHYSICAL
HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment. ***History Form is retained by physician/healthcare provider.***

Name: _____ Date of birth: _____

Date of examination: _____ Grade: _____

Sex assigned at birth (F, M, or intersex): _____

List past and current medical conditions. _____

_____

Have you ever had surgery? It 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).

_____

Are your required vaccinations current? _____

Patient Health Questionnaire Version 4 (PHQ-4)

Overall, during 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 poly-morphic 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, tingling, 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 food and 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: _____

PHYSICAL EXAMINATION

(Physical examination must be performed on or after April 1 by a health care professional holding an unlimited license to practice medicine, a nurse practitioner or a physician assistant to be valid for the following school year.) Rule 3-10

Name _____ Date of Birth _____ Grade _____ IHSAA Member School _____

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, chewing tobacco, snuff, or dip?
   - During the last 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 use any other appearance/performance 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 (questions 5-14)

EXAMINATION		
Height _____ Weight _____ ☐ Male ☐ Female		
BP ____/____ (____/____) Pulse _____ Vision R 20/_____ L 20/_____ Corrected? Y N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance		
• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insuffiency		
Eyes/ears/nose/throat		
• Pupils equal		
• Hearing		
Lymphnodes		
Heart		
• Murmurs (auscultation standing, supine, +/- Valsalva)		
Pulses		
• Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Skin		
• HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic		

MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		

	NORMAL	ABNORMAL FINDINGS
Knee		
Leg/ankle		
Foot/toes		
Functional		
• Double-leg squat test, box drop or step drop test		

☐ Cleared for all sports without restriction ☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

☐ Not cleared ☐ Pending further evaluation ☐ For any sports

Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is 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 clearance 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) _____ Phone _____ Date _____

Address _____ License # _____, MD, DO, PA, or NP (Circle one)

Health Care Professional

PREPARTICIPATION PHYSICAL EVALUATION

IHSAA ELIGIBILITY RULES

INDIVIDUAL ELIGIBILITY RULES (Grades 9 through 12)

ATTENTION ATHLETE: Your school is a member of the IHSAA and follows established rules. To be eligible to represent your school in interschool athletics, you:

1. must be a regular bona fide student in good standing in the school you represent; must have enrolled not later than the fifteenth day of the current semester.
2. must have completed 8 separate days of organized practice in said sport under the direct supervision of the high school coaching staff preceding date of participation in interschool contests. (Excluding Girls Golf – See Rule 101)
3. must have received passing grades at the end of their last grading period in school in at least seventy percent (70%) of the maximum number of full credit subjects (or the equivalent) that a student can take and must be currently enrolled in at least seventy percent (70%) of the maximum number of full credit subjects (or the equivalent) that a student can take. Semester grades take precedence.
4. must not have reached your twentieth birthday prior to or on the scheduled date of the IHSAA State Finals in a sport.
5. must have been enrolled in your present high school last semester or at a junior high school from which your high school receives its students . . .
   - . . . unless you are entering the ninth grade for the first time.
   - . . . unless you are transferring from a school district or territory with a corresponding bona fide move on the part of your parents.
   - . . . unless you are a ward of a court; you are an orphan, you reside with a parent, your former school closed, your former school is not accredited by the state accrediting agency in the state where the school is located, your transfer was pursuant to school board mandate, you attended in error a wrong school, you transferred from a correctional school, you are emancipated, you are a foreign exchange student under an approved CSIET program. You must have been eligible from the school from which you transferred.
6. must not have been enrolled in more than eight consecutive semesters beginning with grade 9.
7. must be an amateur (have not participated under an assumed name, have not accepted money or merchandise directly or indirectly for athletic participation, have not accepted awards, gifts, or honors from colleges or their alumni, have not signed a professional contract).
8. must have had a physical examination between April 1 and your first practice and filed with your principal your completed Consent and Release Certificate.
9. must not have transferred from one school to another for athletic reasons as a result of undue influence or persuasion by any person or group.
10. must not have received in recognition of your athletic ability, any award not approved by your principal or the IHSAA.
11. must not accept awards in the form of merchandise, meals, cash, etc.
12. must not participate in an athletic contest during the IHSAA authorized contest season for that sport as an individual or on any team other than your school team. (See Rule 15-1a) (Exception for outstanding student-athlete – See Rule 15-1b)
13. must not reflect discredit upon your school nor create a disruptive influence on the discipline, good order, moral or educational environment in your school.
14. students with remaining eligibility must not participate in tryouts or demonstrations of athletic ability in that sport as a prospective post-secondary school student-athlete. Graduates should refer to college rules and regulations before participating.
15. must not participate with a student enrolled below grade 9.
16. must not, while on a grade 9 junior high team, participate with or against a student enrolled in grade 11 or 12.
17. must, if absent five or more days due to illness or injury, present to your principal a written verification from a physician licensed to practice medicine, stating you may participate again. (See Rule 3-11 and 9-14.)
18. must not participate in camps, clinics or schools during the IHSAA authorized contest season. Consult your high school principal for regulations regarding out-of-season and summer.
19. girls shall not be permitted to participate in an IHSAA tournament program for boys where there is an IHSAA tournament program for girls in that sport in which they can qualify as a girls tournament entrant.

This is only a brief summary of the eligibility rules.

You may access the IHSAA Eligibility Rules (By-Laws) at www.ihsaa.org

Please contact your school officials for further information and before participating outside your school.

(Consent & Release Certificate - on back or next page)

PREPARTICIPATION PHYSICAL EVALUATION

CONSENT & RELEASE CERTIFICATE

I. STUDENT ACKNOWLEDGMENT AND RELEASE CERTIFICATE

A. I have read the IHSAA Eligibility Rules (next page or on the back) and know of no reason why I am not eligible to represent my school in athletic com- petition.

B. If accepted as a representative, I agree to follow the rules and abide by the decisions of my school and the IHSAA.

C. I know that athletic participation is a privilege. I know of the risks involved in athletic participation, understand that serious injury, illness and even death, is a possible result of such participation, and choose to accept such risks. I voluntarily accept any and all responsibility for my own safety and welfare while participating in athletics, with full understanding of the risks involved, and agree to release and hold harmless my school, the schools involved and the IHSAA of and from any and all responsibility and liability, including any from their own negligence, for any injury, illness or claim resulting from such athletic participation and agree to take no legal action against my school, the schools involved or the IHSAA because of any accident or mishap involving my athletic participation.

D. I consent to the exclusive jurisdiction and venue of courts in Marion County, Indiana for all claims and disputes between and among the IHSAA and me, including but not limited to any claims or disputes involving injury, eligibility or rule violation.

E. I give the IHSAA and its assigns, licensees and legal representatives the irrevocable right to use my picture or image and any sound recording of me, in all forms and media and in all manners, for any lawful purposes.

I HAVE READ THIS CAREFULLY AND KNOW IT CONTAINS A RELEASE PROVISION. (to be signed by student)

Date:_____ **Student Signature: (X)** _____

Printed: _____

II. PARENT/GUARDIAN/EMANCIPATED STUDENT CONSENT, ACKNOWLEDGMENT AND RELEASE CERTIFICATE

A. Undersigned, a parent of a student, a guardian of a student or an emancipated student, hereby gives consent for the student to participation in the following interschool sports ***not marked out:***
Boys Sports: Baseball, Basketball, Cross Country, Football, Golf, Soccer, Swimming & Diving, Tennis, Track & Field, Volleyball, Wrestling.
Girls Sports: Basketball, Cross Country, Golf, Gymnastics, Soccer, Softball, Swimming & Diving, Tennis, Track & Field, Volleyball, Wrestling.
Unified Sports: Unified Flag Football, Unified Track & Field

B. Undersigned understands that participation may necessitate an early dismissal from classes.

C. Undersigned consents to the disclosure, by the student's school, to the IHSAA of all requested, detailed financial (athletic or otherwise), scholastic and attendance records of such school concerning the student.

D. Undersigned knows of and acknowledges that the student knows of the risks involved in athletic participation, understands that serious injury, illness and even death, is a possible result of such participation and chooses to accept any and all responsibility for the student's safety and welfare while participating in athletics. With full understanding of the risks involved, undersigned releases and holds harmless the student's school, the schools involved and the IHSAA of and from any and all responsibility and liability, including any from their own negligence, for any injury or claim resulting from such athletic participation and agrees to take no legal action against the IHSAA or the schools involved because of any accident or mishap involving the student's athletic participation.

E. Undersigned consents to the exclusive jurisdiction and venue of courts in Marion County, Indiana for all claims and disputes between and among the IHSAA and me or the student, including but not limited to any claims or disputes involving injury, eligibility, or rule violation.

F. Undersigned gives the IHSAA and its assigns, licensees and legal representatives the irrevocable right to use any picture or image or sound recording of the student in all forms and media and in all manners, for any lawful purposes.

G. Please check the **appropriate space:**

❑ The student has adequate family insurance coverage. ❑ The student does not have insurance

❑ The student has football insurance through school.

Company: _____ Policy Number: _____

I HAVE READ THIS CAREFULLY AND KNOW IT CONTAINS A RELEASE PROVISION.
(to be completed and signed by all parents/guardians, emancipated students; where divorce or separation, parent with legal custody must sign)

Date: _____ **Parent/Guardian/Emancipated Student Signature:** (X) _____

Printed: _____

Date: _____ **Parent/Guardian Signture:** (X) _____

Printed: _____

CONSENT & RELEASE CERTIFICATE
Indiana High School Athletic Association, Inc.
9150 North Meridian St.
Indianapolis, IN 46260-1802

File In Office of the Principal
Separate Form Required for Each School Year

DLC: 1/15/2025