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

TMS Interscholastic Sports Permission Slip

Students must be in good academic standing and have received less than five (5) detentions and/or two (2) suspensions during the current quarter to participate.
Students who meet the following criteria will have their "good" academic status revoked:

- Average between 64 and 70 in two or more subjects

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 for which they are trying out.

FINANCIAL ASSISTANCE

TMS sports are run on a "Pay to Participate" basis. Please see our website for more information. Financial assistance may be available to those in need. Please contact Principal Willett requesting such assistance in writing *at least 5 days prior to official deadline dates below*. Requests are for a specific student, and sport, and must be resubmitted for each new season and sport.

DEADLINES FOR PARTICIPATION:

The *TMS Interscholastic Sports Permission Slip* and the *Connecticut Pre-participation Sports Evaluation*, *must* be submitted to the *Nurse's Office* at Tolland Middle School on or before the following dates for the students to participate in any aspect of the sport, including tryouts. If you have missed the deadline, you may download the *Sports Eligibility Appeal form* from our website, and submit it to the Principal's Office for consideration. Forms will only be accepted after the deadline in cases of extreme hardship. Families should plan well ahead of these deadlines and follow through with doctors' offices to allow enough time for paperwork to be submitted prior to the deadline.

SEASON	SPORT	DEADLINE
FALL	Boys Soccer, Girls Soccer, Cross Country	**The day after Labor Day**
WINTER	Boys Basketball, Girls Basketball, Cheerleading	**The first school day of November**
SPRING	Baseball, Softball, Track	**The first school day of March**

Parents should be aware that there are 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
Student's Name
STUDENTS MUST HAVE EMERGENCY CONTACT INFORMATION:

Home:_____ Cell:_____ Work:_____

I give consent for _____ to participate in _____
Student activity

_____ _____
Parent's Signature Date

_____ _____
Athlete's Signature Coach's 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, time and patience, so you can participate 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 from 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 form 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 two weeks prior to the tryout.

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.

Tolland Public Schools
Department of Food Service

51 Tolland Green Tolland, Connecticut 06084
(860) 870-6853 Fax (860) 870-7737

2012-2013 SHARING INFORMATION WITH OTHER PROGRAMS

2012-2013 SHARING INFORMATION WITH OTHER PROGRAMS

Dear Parent/Guardian of students receiving meal benefits:
To save you time and effort, the information you submitted on your Free and Reduced Price School Meals Application may be shared with other programs for which your children *may* qualify. For the following programs, we must have your permission to share this information. Please sign for these additional benefits below if you are interested in receiving them. By signing, you are certifying that you are the parent/guardian of the child(ren) for whom the application is being made.

Note: *Sending in this form will not change whether your children receive free or reduced price meals.*

☐ No! I do **NOT** want information from my Free and Reduced Price School Meals Application shared with any of these programs.

☐ Yes! I **DO** want school officials to share information from my Free and Reduced Price School Meals Application for Tolland Public Schools Pay to Participate Fees (i.e. athletics, co-curricular activities)

☐ Yes! I **DO** want school officials to share information from my Free and Reduced Price School Meals Application for Tolland Public Schools Field Trips if applicable.

If you checked yes to any or all of the boxes above, complete the information below and sign the form. Your information will be shared only with the programs you checked.

Child's Name: _____ School: _____

Child's Name: _____ School: _____

Child's Name: _____ School: _____

Child's Name: _____ School: _____

Signature of Parent/Guardian: _____ **Date:** _____

Printed Name: _____Phone:_____

Address: _____ _____

For more information, you may call Abby Kassman-Harned, Director of Food Service at 860-870-6853 or email aharned@tolland.k12.ct.us.
Return this form to: Director of Food Service, Tolland Public Schools, 51 Tolland Green, Tolland CT 06084

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 _____

In case of emergency, contact

Name _____ Relationship _____ Phone (H) _____ (W) _____

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

	Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?	☐	☐
Do you have an ongoing or chronic illness (Diabetes, Epilepsy, Sickle Cell Disease, Kawasaki's Disease, Marfan's Syndrome or any handicap)?	☐	☐
2. Have you ever been hospitalized overnight?	☐	☐
Have you ever had surgery?	☐	☐
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)?	☐	☐
Have you ever taken any supplements, creatine, steroids, or vitamins to help you gain or lose weight or improve your performance?	☐	☐
4. Do you have any allergies (for example, to pollen, medicine, food or stinging insects)?	☐	☐
Have you ever had a rash or hives develop during or after exercise?	☐	☐
5. Have you ever passed out during or after exercise?	☐	☐
Have you ever been dizzy during or after exercise?	☐	☐
Have you ever had chest pain during or after exercise?	☐	☐
Do you get tired more quickly than your friends do during exercise?	☐	☐
Have you ever had racing of your heart or skipped heartbeats?	☐	☐
Have you had high blood pressure or high cholesterol?	☐	☐
Have you ever been told you have a heart murmur?	☐	☐
Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
Have you had a severe viral infection (for example, myocarditis or mononucleosis)?	☐	☐
Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	☐	☐
7. Have you ever had a head injury or concussion?	☐	☐
Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐
Have you ever had a seizure?	☐	☐
Do you have frequent or severe headaches?	☐	☐
Have you ever had numbness or tingling in your arms, hands, legs or feet?	☐	☐
Have you ever had a stinger, burner or pinched nerve?	☐	☐
Have you had a neck, spine or low back injury or pain?	☐	☐
8. Have you ever become ill from exercising in the heat?	☐	☐
9. Do you cough, wheeze, or have trouble breathing during or after activity?	☐	☐
Do you have asthma?	☐	☐
Do you have seasonal allergies that require medical treatment?	☐	☐
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)?	☐	☐

	Yes	No
11. Have you had any problems with your eyes or vision?	☐	☐
Do you wear glasses, contacts, or protective eyewear?	☐	☐
Do you bruise easily, take a long time to stop bleeding, or have frequent nose bleeds?	☐	☐
Have you had infectious mononucleosis or hepatitis?	☐	☐
Do you have hearing loss, tubes in your ears, or a perforated eardrum?	☐	☐
Do you have kidney disease or dark brown bloody urine?	☐	☐
Do you have less than 2 kidneys or, in males, less than two testicles?	☐	☐
Do you have diarrhea more than once a week, or black/bloody bowel movements (stools)?	☐	☐
Do you have lump(s) in the armpit or groin?	☐	☐
12. Have you ever had a sprain, strain, or swelling after injury?	☐	☐
Have you broken or fractured any bones or dislocated any joints?	☐	☐
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	☐	☐

If yes, check appropriate box and explain below:

☐ Head	☐ Elbow	☐ Hip
☐ Neck	☐ Forearm	☐ Thigh
☐ Back	☐ Wrist	☐ Knee
☐ Chest	☐ Hand	☐ Shin/calf
☐ Shoulder	☐ Finger	☐ Ankle
☐ Upper arm		☐ Foot

13. Do you want to weigh more or less than you do now?	☐	☐
Do you lose weight regularly to meet weight requirements for your sport?	☐	☐
Have you lost or gained more than 10 pounds in the past year?	☐	☐
Are you on a special diet?	☐	☐
14. Do you feel stressed out?	☐	☐

15. Record the dates of your most recent immunizations (shots) for:
Tetanus _____ Measles _____
Hepatitis B _____ Chickenpox _____
Meningococcus _____

FEMALES ONLY

16. When was your first menstrual period?
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 _____

MEDICAL

	NORMAL	ABNORMAL FINDINGS	INITIALS
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			

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