



2010-2011 U.I.L Athletic Participation Form

DeSoto Independent School District



Grade 2010-2011: 7 8 (East West McCowan) 9 10 11 12 Sex: M F Sports:

BACKGROUND INFORMATION

Athlete's Full Name _____ DOB _____ Age _____ ID# _____
 Athlete's SS # _____ Home Address _____
 Home Phone # _____ City _____ Zip _____
 Father's Name _____ SS# _____ Home Phone _____ Wk Phone _____
 Father's Cell Phone _____ Father's Email _____
 Father's Employer's Company/Name _____ City _____
 Mother's Name _____ SS# _____ Home Phone _____ Wk Phone _____
 Mother's Cell Phone _____ Mother's Email _____
 Mother's Employer's Company/Name _____ City _____

EMERGENCY INFORMATION

Other Person to call in case of Emergency if Parents cannot be reached:
 Name _____ Relation _____ Phone # _____
 Name _____ Relation _____ Phone # _____
 Family Physician _____ Family Physician Phone # _____
 Allergies to medicine or other (please list) _____
 Any medicine taking regularly (please list) _____
 Any medical concerns that should be noted _____
 What is your Sickle Cell Trait status? (Positive or Negative) *please see enclosed information* _____

INSURANCE INFORMATION

Is there Health Insurance covering this student _____ **YES** _____ **NO** This policy is _____ **HMO** _____ **PPO**
 Name Insurance is listed under _____ Group / Policy # _____
 Insurance Company Name _____ Phone # _____

ACKNOWLEDGEMENT OF RULES & GUIDLINES

The Parent/Legal Guardian and the Student must have read all the following regulations and sections and agree to follow the rules and sign below attesting to the fact: Background, Emergency & Insurance Information and Completed Notarized Medical Consent, DeSoto ISD Insurance Policy and Claim Procedure (Separate Handout Enclosed), Sickle Cell Trait Educational Guide (Separate Handout Enclosed) , UIL General Eligibility Rules, Parent or Guardian Permit, Participation Notification, Medication Permit, Athletic Training Room Guidelines (Separate Handout Enclosed), Release to Return to Play after Medical Consultation, Medical History and Physical Exam, and I permit my child to participate under these conditions. I have completed the information to the best of my knowledge and ability.

X _____ X _____
Parent/Legal Guardian Signature **Date** **Student Signature** **Date**

NOTARIZED MEDICAL CONSENT

(I) (We) the undersigned, parent(s)/legal guardian(s) of _____, a minor, do hereby authorize the DeSoto Independent School District athletic staff as agent(s) for the undersigned to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of and licensed physician/surgeon, whether such diagnosis or treatment is rendered at the office of said physician/surgeon or at a hospital .It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital which has provided treatment to the above-named minor to surrender physical custody of such minor to (my) (our) above-named agent(s) upon the completion of treatment. Before me the undersigned authority, on this day personally appeared the following person(s) whose name(s) is/are subscribed to the foregoing instrument, and acknowledged to me that he/she/they executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office on this _____ day of _____, 201__ Notary Public in and for _____ County, Texas.

X

Parent/Legal Guardian Signature

X

Notary Signature and Stamp

PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

REVISED 1-6-09

This **MEDICAL HISTORY FORM** must be completed *annually* by parent (or guardian) and student in order for the student to participate in athletic activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an athletic event.

Student's Name: (print) _____ Sex _____ Age _____ Date of Birth _____
 Address _____ Phone _____
 Grade _____ School _____
 Personal Physician _____ Phone _____

In case of emergency, contact:

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

Explain "Yes" answers in the box below. Circle questions you don't know the answers to. Any Yes answer to questions 1, 2, 3, 4, 5, or 6 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physician assistant, chiropractor, or nurse practitioner is required before any participation in UIL practices, games or matches**

	Yes	No		Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you ever gotten unexpectedly short of breath with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been hospitalized overnight in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	14. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever had a sprain, strain, or swelling after injury?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have you broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, check appropriate box and explain below.		
Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip
Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh
Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome or other ion channelopathy (Brugada syndrome, etc), Marfan's syndrome, or abnormal heart rhythm?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Knee
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Shin/Calf
Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger	<input type="checkbox"/> Ankle
4. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Foot	
Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you want to weigh more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how many _____ When was the last _____ times? _____ concussion?			Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
How severe was each one? (Explain below)			17. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	Females Only		
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	<input type="checkbox"/>	<input type="checkbox"/>	19. When was your first menstrual period? _____		
Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	When was your most recent menstrual period? _____		
5. Are you missing any paired organs?	<input type="checkbox"/>	<input type="checkbox"/>	How much time do you usually have from the start of one period to the start of another? _____		
6. Are you under a doctor's care?	<input type="checkbox"/>	<input type="checkbox"/>	How many periods have you had in the last year? _____		
7. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	What was the longest time between periods in the last year? _____		
8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>	An individual answering in the affirmative to any question relating to a possible cardiovascular health issue (question three above), as identified on the form, should be restricted from further participation until the individual is examined and cleared by a physician, physician assistant, chiropractor, or nurse practitioner.		
9. Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	**EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary):		
10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
11. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
12. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>	_____		

It is understood that even though protective equipment is worn by the athlete, whenever needed, the possibility of an accident still remains. Neither the University Interscholastic League nor the school assumes any responsibility in case an accident occurs.

If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student.

If, between this date and the beginning of athletic competition, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide truthful responses could subject the student in question to penalties determined by the UIL

Student Signature: _____ Parent/Guardian Signature: _____ Date: _____

THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE OR CONTEST BEFORE, DURING OR AFTER SCHOOL.

For School Use Only:

This Medical History Form was reviewed by: Printed Name _____ Date _____ Signature _____

SIGNATURES ARE REQUIRED

PREPARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAMINATION

Student's Name _____ Sex _____ Age _____ Date of Birth _____

Height _____ Weight _____ % Body fat (optional) _____ Pulse _____ BP _____/_____/_____ (_____/_____, ____/_____)
brachial blood pressure while sitting

Vision R 20/____ L 20/____ Corrected: Y N Pupils: Equal Unequal

As a minimum requirement, this **Physical Examination Form** must be completed prior to junior high athletic participation and again prior to first and third years of high school athletic participation. It **must** be completed if there are yes answers to specific questions on the student's MEDICAL HISTORY FORM on the reverse side. *** Local district policy may require an annual physical exam.**

NORMAL

ABNORMAL FINDINGS

INITIALS*

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in the supine position.			
Heart-Auscultation of the heart in the standing position.			
Heart-Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			

MUSCULOSKELETAL

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

*station-based examination only

CLEARANCE

- Cleared
- Cleared after completing evaluation/rehabilitation for: _____

Not cleared for: _____ Reason: _____

Recommendations: _____

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner, will not be accepted.

Name (print/type) _____ Date of Examination: _____

Address: _____

Phone Number: _____

Signature: _____

Must be completed before a student participates in any practice, before, during or after school, (both in-season and out-of-season) or games/matches.

General Information

School coaches may not:

- Transport, register, or instruct students in grades 7-12 from their attendance zone in non-school baseball, basketball, football, soccer, softball, or volleyball camps (exception: school coaches may hold one 6-day camp in their school district for incoming 7th, 8th, and 9th grade students).
- Give any instruction or schedule any practice for an individual or a team during the off-season except during the one in school day athletic period in baseball, basketball, soccer, softball, or volleyball.
- Schools and school booster clubs may not provide funds, fees, or transportation for non-school activities.

General Eligibility Rules

According to UIL standards, students are eligible to represent their school in interscholastic activities if they:

- are not 19 years of age or older on or before September 1 of the current scholastic year. (see 504 handicapped exception)
- have not graduated from high school.
- are enrolled by the 6th class day of the current school year or have been in attendance for 15 calendar days immediately preceding a varsity contest.
- are full-time, day students in a participant high school.
- initially enrolled in the 9th grade not more than 4 calendar years ago.
- are meeting academic standards required by state law.
- live with their parents inside the school district attendance zone their first year of attendance. (Parent residence applies to varsity athletic eligibility only.) When the parents do not reside inside the district attendance zone the student could be eligible if: the student has been in continuous attendance for at least one calendar year and has not enrolled at another school; no inducement is given to the student to attend the school (for example: students or their parents must pay their room and board when they do not live with a relative; students driving back into the district should pay their own transportation costs); and it is not a violation of local school or TEA policies for the student to continue attending school. Students placed by the Texas Youth Commission are covered under Custodial Residence (see Section 442 of the Constitution and Contest Rules).
- have observed all provisions of the Awards Rule.
- have not represented a college in a contest.
- have not been recruited. (Does not apply to college recruiting as permitted by rule).
- have not violated any provision of the summer camp rule. Incoming 10-12 grade students shall not attend a baseball, football, soccer, or volleyball camp in which a 7th-12th grade coach from their school district attendance zone, works with, instructs, transports or registers that student in the camp. Students who will be in grades 7, 8, and 9 may attend one baseball, one basketball, one football, one soccer, one softball, and one volleyball camp in which a coach from their school district attendance zone is employed, for no more than six consecutive days each summer in each type of sports camp. Baseball, Basketball, Football, Soccer, Softball, and Volleyball camps where school personnel work with their own students may be held in May, after the last day of school, June, July, and August prior to the second Monday in August. If such camps are sponsored by school district personnel, they must be held within the boundaries of the school district and the superintendent or his designee shall approve the schedule of fees.
- have observed all provisions of the Athletic Amateur Rule. Students may not accept money or valuable consideration (tangible or intangible property or service including anything that is usable, wearable, salable or consumable) for participating in any athletic sport during any part of the year. Athletes shall not allow their names to be used for the promotion of any product, plan or service. Students who inadvertently violate the amateur rule by accepting valuable consideration may regain athletic eligibility by returning the valuable consideration. If individuals return the valuable consideration within 30 days after they are informed of the rule violation, they regain their athletic eligibility when they return it. If they fail to return it within 30 days, they remain ineligible for one year from when they accepted it. During the period of time from when students receive valuable consideration until they return it, they are ineligible for varsity athletic competition in the sport in which the violation occurred. Minimum penalty for participating in a contest while ineligible is forfeiture of the contest.
- did not change schools for athletic purposes.

Parent or Guardian's Permit

I hereby give my consent for the above student to compete in University Interscholastic League approved sports, and travel with the coach or other representative of the school on any trips.

It is understood that even though protective equipment is worn by the athlete whenever needed, the possibility of an accident still remains. Neither the University Interscholastic League nor the high school assumes any responsibility in case an accident occurs.

I have read and understand the University Interscholastic League rules on the reverse side of this form and agree that my son/daughter will abide by all of the University Interscholastic League rules.

The undersigned agrees to be responsible for the safe return of all athletic equipment issued by the school to the above named student.

If, in the judgment of any representatives of the school, the above student needs immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given to said student by any physician, athletic trainer, nurse, hospital, or school representative; and I do hereby agree to indemnify and save harmless the school and any school representative from any claim by any person whomsoever on account of such care and treatment of said student. **In addition, I understand that pre-participation screening examinations will not prevent, nor detect, all conditions leading to traumatic injury and/or sudden death.**

I have been provided the UIL Parent Information Manual regarding health and safety issues and my responsibilities as a parent/guardian. I understand that failure to provide accurate and truthful information on UIL forms could subject the student in question to penalties determined by the UIL.

Your signature gives authorization that is necessary for the school district, its athletic trainers, coaches, associated physicians and student insurance personnel to share information concerning medical diagnosis and treatment for your student.

Medication Permit and Return to Play Criteria

Licensed Athletic trainers designated by the DeSoto Independent School District board policy are hereby given my consent to administer non-prescription medication to said student. Further consent is hereby given to administer prescription medication to said student when prescribed by the team physician and /or student's personal physician.

Athletes who seek medical attention from a Healthcare provider cannot return to Athletic Participation without the following two criteria:

1. a signed/dated release from a Medical Physician on file with the DeSoto ISD Athletic Trainers, AND
2. release by the DeSoto ISD Licensed Athletic Trainers

* Note (Parental Authorization and/or Notification WILL NOT be accepted *

DESOTO I.S.D. INSURANCE POLICY CLAIM PROCEDURES

If you do not have personal health insurance coverage, we recommend you purchase a plan through our Voluntary Student Insurance program.

Parents, please read carefully: _____

The school will provide a catastrophic insurance plan for each athletic participant in the DISD grades 7-12.

An accident insurance policy has been purchased in which DeSoto ISD pays the premium. This is a secondary policy that will help cover the deductible from the family's primary carrier. (The district policy will coordinate with the individual's coverage). If you have no other insurance, the DISD policy is the primary carrier.

Each covered person for whom the DISD policy has been paid will be covered for injury that occurs:

- (a) on or after the first day of scheduled practice,
- (b) up to the last day of school following the policy date, and
- (c) while the covered person is practicing for or participating in regularly scheduled UIL activities.

The accident policy under DISD is a limited benefit plan. **This plan will not pay 100% of the bills.** This means that the policy will only pay a small portion of medical bills and that the student's parents are responsible for the remainder of the charges. In some cases, there is a network of providers available that will take some benefits on full assignment with the DISD plan. To be covered under the school policy, the student must receive medical treatment within 30 days of the accident and treatment will only be covered for 52 weeks. An insurance claim must be filed within 90 days of the accident in order for the student to receive any benefits from this policy.

What to do if your son/daughter is injured: _____

Immediately contact the Athletic Trainer at DeSoto High School: Scott Galloway, L.A.T., A.T.C. at (972) 274-8118 located at 700 Eagle Drive, DeSoto, TX 75115. Fax: (972) 274-8113. **The school must be able to document that the injury was a result of an accident occurring during a school UIL practice or event for the school insurance claim to be completed.**

The Athletic Trainers will assist you in filling out an Insurance claim form so that your healthcare provider can file with the school insurance. **You are responsible for ensuring that a claim has been filed.** The Athletic Trainers can also assist you with any questions in regards to billing, insurance and healthcare providers.

If you have personal insurance coverage or are a part of an HMO or PPO, have your healthcare provider file all claims with your insurance carrier first. The hospital, clinic, or doctor can then file the E.O.B.'s (Explanation of Benefits) with the school insurance carrier along with the itemized bills. The healthcare provider will be paid the balance due up to the policy limits. **After both policies have been paid there could be some additional expenses, which will be the responsibility of the parent or guardian.**

If you do not have personal insurance coverage you will have to ask the healthcare provider if they will file the claim with the School Insurance Policy. You may have to pay for all services in advance. If so, keep all receipts, itemized bills and diagnosis so that you can file with the school insurance policy.

RETAIN THIS FORM FOR FUTURE REFERENCE!

DESOTO SPORTS MEDICINE

WHAT IS A LICENSED ATHLETIC TRAINER?

Recognized by the American Medical Association as an Allied Health Profession, the Licensed Athletic Trainer is a well-trained professional and an integral part of a complete athletic program. The role of the Licensed Athletic Trainer includes prevention, treatment and rehabilitation of athletic injuries as well as education and counseling of athletes. A Licensed Athletic Trainer has a thorough knowledge of anatomy, physiology, psychology, nutrition, conditioning and other related areas. The DeSoto Athletic Training Staff is pleased to work in conjunction with Southwest Orthopedics & Sports Medicine to assist you in facilitating the most appropriate care for your child. Feel free to contact us if you have any questions regarding your child's injury.

ATHLETIC TRAINING ROOM RULES OF CONDUCT

1. Report every injury at the end of practice. If it develops overnight, the Athletic Training Room hours will be before school, during all four lunches, and immediately after school. If you are not present, it will be assumed that you are able and ready to practice that day.
2. If not an emergency, please clean up before coming to the Athletic Training Room and wear suitable clothing.
3. Please **DO NOT WEAR SHOES** in the Athletic Training Room.
4. If you are to receive treatment or taping, please be patient and wait your turn. When you are finished, leave the Athletic Training Room so that others may be attended to.
5. Please do not lie down or sit on the treatment tables unless instructed to do so.
6. No food or drink is allowed in the Athletic Training Room by the athletes.
7. Taking items from the Athletic Training Room without permission by the Professional or Student Athletic Trainers is stealing and punishable by district policy.
8. Athletes are not permitted to operate any Athletic Training Room Equipment or Modalities.
9. Athletes are responsible for all items issued to them. If it is not returned, the athlete will be responsible for the replacement cost of the items.
10. There will be no fighting, roughhousing, or throwing things in the Athletic Training Room.
11. No tobacco, alcohol or drugs of any kind will be tolerated in the Athletic Training Room and are punishable by district policy.
12. The student athletic trainers are to assist the Professional Athletic Trainers. Please respect them and their services. Disrespect and /or mistreatment of the student trainers will not be tolerated.

NOTE: IF REPEATED VIOLATIONS OCCUR, THE ATHLETE STANDS LOSE ATHLETIC TRAINING PRIVILEGES

SICKLE CELL TRAIT AND THE ATHLETE

WHAT IS SICKLE CELL TRAIT?

Sickle cell trait is common and generally benign. More than 3 million Americans have sickle trait and almost all live healthy, normal lives. Yet for some athletes, sickle trait can pose a grave problem—a problem that can even cause death. Athletes with sickle trait inherit one gene for normal hemoglobin and one gene for sickle hemoglobin (hemoglobin S). If oxygen in tissues falls to low levels, the red cells carrying the hemoglobin S can change from the usual disk shape to a crescent or sickle shape. These sickled red cells can clog blood vessels, impairing the delivery of oxygen and removal of harmful metabolites, resulting in severe damage to involved tissues (i.e. heart, lungs, liver). Understanding sickle cell trait is vital to athletes, coaches, and athletic trainers because sickling injuries are preventable with screening and proper precautions.

WHY SHOULD I BE CONCERNED?

In the past four decades, exertional sickling has killed at least 15 football players. In the past seven years alone, sickling has killed nine athletes: five college football players in training, two high school athletes (one a 14-year-old female basketball player), and two 12-year-old boys training for football. Of 136 sudden, non-traumatic sports deaths in high school and college athletes over a decade, seven (5%) were from exertional sickling.

WHAT CAN I DO TO ENSURE SAFE PARTICIPATION?

As all fifty states screen for sickle cell trait at birth, this marker is a base element of personal health information that should be made readily available to the athlete, the athlete's parents, and to the athlete's healthcare provider, including those providers responsible for determination of medical eligibility for participation in sports. **If you are currently unaware of your sickle cell trait status, we recommend you contact your pediatrician to obtain the screening results or to be screened.** This information is also available through the Texas Department of State Health Services' Newborn Screening Program. <http://www.dshs.state.tx.us/newborn/default.shtm>

DeSoto I.S.D encourages all participants to know their sickle cell trait status and note it accordingly on the Athletic Participation Form. We maintain that knowledge of sickle cell trait status is the gateway to the tandem tenets of education and simple precautions that can prevent sickling collapse and enable sickle cell trait athletes to thrive in sport. If the athlete lacks documentation, we recommend screening to determine his/her sickle trait status.

Special Acknowledgement:

**E. Randy Eichner, MD
Professor Emeritus of Medicine and Team Internist
University of Oklahoma, Norman, OK**

**National Athletic Trainers' Association
Inter-Association Task Force
Sickle Cell Trait and the Athlete**

