COPY THIS PAGE for the student to return to the school. **KEEP** the complete document in the student's medical record.

2025-2026 SPORTS QUALIFYING PHYSICAL EXAMINATION MEDICAL ELIGIBILITY FORM

Minnesota State High School League

Student Name:_____ Birth Date: _____
Address:_____
Home Telephone: _____ - _____ - _____ Mobile Telephone _____ - _____ - _____
School:_____ Grade: _____

I certify that the above student has been medically evaluated and is deemed medically eligible to: (Check Only One Box)

☐ **(1) Participate in all school interscholastic activities without restrictions.**
☐ **(2) Participate in any activity not crossed out below.**

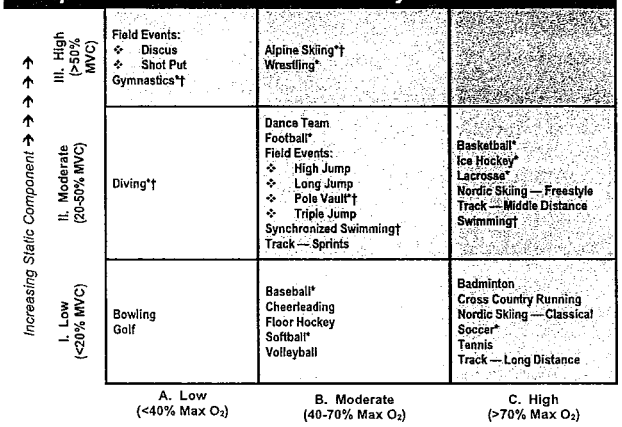
Sport Classification Based on Contact

Collision Contact Sports	Limited Contact Sports	Non-contact Sports
Basketball	Baseball	Badminton
Cheerleading	Field Events:	Bowling
Diving	❖ High Jump	Cross Country Running
Football	❖ Long Jump	Dance Team
Gymnastics	❖ Pole Vault	Field Events:
Ice Hockey	❖ Triple Jump	❖ Discus
Lacrosse	Floor Hockey	❖ Shot Put
Alpine Skiing	Nordic Skiing	Golf
Soccer	Softball	Swimming
Wrestling	Volleyball	Tennis
		Track

☐ **(3) Requires additional evaluation before a final recommendation can be made.**
Additional recommendations for the school or parents:
_____
_____

☐ **(4) Not medically eligible for:** ☐ **All Sports** ☐ **Specific Sports**
Specify _____

Sport Classification Based on Intensity & Strenuousness



Sport Classification Based on Intensity & Strenuousness: This classification is based on peak static and dynamic components achieved during competition. It should be noted, however, that higher values may be reached during training. The increasing dynamic component is defined in terms of the estimated percent of maximal oxygen uptake ($MaxO_2$) achieved and results in an increasing cardiac output. The increasing static component is related to the estimated percent of maximal voluntary contraction (MVC) reached and results in an increasing blood pressure load. The lowest total cardiovascular demands (cardiac output and blood pressure) are shown in lightest shading and the highest in darkest shading. The graduated shading in between depicts low moderate, moderate, and high moderate total cardiovascular demands. *Danger of bodily collision. †Increased risk if syncope occurs. Reprinted with permission from: Maron BJ, Zipes DP. 36th Bethesda Conference: eligibility recommendations for competitive athletes with cardiovascular abnormalities. *J Am Coll Cardiol.* 2005; 45(8):1317–1375.

I have examined the student named on this form and completed the Sports Qualifying Physical Exam as required by the Minnesota State High School League. The athlete does not have apparent clinical contraindications to practice and participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Provider Signature _____ Date of Exam_____
Print Provider Name: _____
Office/Clinic Name _____ Address: _____
City, State, Zip Code _____
Office Telephone: _____ - _____ - _____ E-Mail Address: _____

IMMUNIZATIONS [Tdap; meningococcal (MCV4, 2 doses); HPV (3 doses); MMR (2 doses); hep B (3 doses); hep A (2 doses); varicella (2 doses or history of disease); polio (3-4 doses); influenza (annual); COVID-19 (2 doses, 1 dose)]
☐ Up to date (see attached school documentation) ☐ Not reviewed at this visit
IMMUNIZATIONS GIVEN TODAY: _____

EMERGENCY INFORMATION
Allergies _____
Other Information _____
Emergency Contact:_____ Relationship _____
Telephone: (Home) _____ - _____ - _____ (Work) _____ - _____ - _____ (Cell) _____ - _____ - _____
Personal Medical Provider _____ Office Telephone _____ - _____ - _____

This form is valid for 3 calendar years from above date with a normal Annual Health Questionnaire.
FOR SCHOOL ADMINISTRATION USE: ☐ [Year 2 Normal] ☐ [Year 3 Normal]

Reference: Preparticipation Physical Evaluation (5th Edition): AAFP, AAP, ACSM, AMSSM, AOSSM, AOASM; 2019.

FORMULARIO DE ANTECEDENTES FÍSICOS DE APTITUD DEPORTIVA 2024-2025

Minnesota State High School League

El proveedor médico que lleve a cabo esta exploración física debe ARCHIVAR las páginas 2-5 de este documento. Instrucciones: Complete y firme este formulario (con su padre/madre si es menor de 18 años) antes de su cita.

Nombre: _____ Fecha de nacimiento_____
Fecha del examen: _____ Deporte(s): _____
Sexo asignado al nacer (F, M o intersexual): _____ ¿Cómo identifica su género? (F, M, no binario u otro género)
¿Tuvo COVID-19? S / N ¿Recibió la vacuna contra el COVID-19? S / N ¿1, 2, or 3 dosis? (Encierre en un círculo) 1 2 3
Condiciones médicas anteriores y actuales: _____
¿Alguna vez tuvo cirugía? En caso afirmativo, enumere todas las cirugías anteriores_____
Enumere los medicamentos y suplementos actuales: recetados, de venta libre y suplementos herbales o nutricionales.
_____
¿Tiene alguna alergia? En caso afirmativo, indique todas sus alergias (es decir, medicamentos, pólenes, alimentos, picaduras de insectos).

Cuestionario de salud del/de la paciente - Versión 4 (PHQ-4)

En las últimas 2 semanas, ¿con qué frecuencia le molestó alguno de los siguientes problemas? (Encierre la respuesta en un círculo).

	En absoluto	Varios días	Más de la mitad días	Casi todos los días
Se sintió nervioso/a, ansioso/a o inquieto/a	0	1	2	3
No pudo parar o controlar su preocupación	0	1	2	3
Sintió poco interés o placer por hacer las cosas	0	1	2	3
Se sintió decaído/a, deprimido/a o desesperanzado/a	0	1	2	3

(Si la suma de las respuestas a las preguntas 1 y 2 o 3 y 4 es ≥3, evalúe al/a la paciente).

Encierre en un círculo los números de las preguntas para las cuales desconozca la respuesta. Encierre S en un círculo para responder Sí y N para No

PREGUNTAS GENERALES
1. ¿Tiene alguna inquietud que le gustaría discutir con su proveedor médico? ..... Si / no
2. ¿Alguna vez un proveedor médico le negó la autorización o restringió su participación en deportes por algún motivo? ..... Si / no
3. ¿Tiene algún problema médico continuo o enfermedad reciente? ..... Si / no

PREGUNTAS IMPORTANTES SOBRE LA SALUD DE SU CORAZÓN [a]
4. ¿Alguna vez se desmayó o casi se desmayó durante o después de hacer ejercicio? ..... Si / no
5. ¿Alguna vez tuvo molestias, dolor, opresión o presión en el pecho cuando hacía ejercicio? ..... Si / no
6. ¿Su corazón alguna vez se acelera o se saltea latidos (latidos irregulares) cuando hace ejercicio? ..... Si / no
7. ¿Alguna vez le dijo un médico que tiene algún problema cardíaco? ..... Si / no
8. ¿Alguna vez un médico solicitó un examen médico para su corazón? Por ejemplo, electrocardiograma (EKG) o ecocardiograma (ECO).. ..... Si / no
9. ¿Se siente mareado/a o le falta el aire más que a sus compañeros/as durante el ejercicio? ..... Si / no
10. ¿Alguna vez tuvo una convulsión? ..... Si / no

PREGUNTAS IMPORTANTES SOBRE LA SALUD DEL CORAZÓN DE SU FAMILIA[a]
11. ¿Alguien de su familia inmediata o familiar falleció por problemas cardíacos o sufrió una muerte súbita e inexplicable antes de los 35 años (Incluyendo ahogamiento o accidente automovilístico inexplicable)? ..... Si / no
12. ¿Alguien en su familia tiene un problema cardíaco genético, como cardiomiopatía hipertrófica (HCM), síndrome de Marfan, miocardiopatía arritmogénica ventrícular derecha (ARVC), síndrome de QT largo (LQTS) o corto (SQTS), síndrome de Brugada o taquicardia ventricular polimórfica catecolaminérgica ..... Si / no
13. ¿Alguien en su familia recibió un marcapasos o un desfibrilador implantable antes de los 35 años? ..... Si / no

PREGUNTAS SOBRE HUESOS Y ARTICULACIONES
14. ¿Alguna vez sufrió una fractura por fatiga o una lesión en un hueso, músculo, ligamento, articulación o tendón que le hizo perder un entrenamiento o partido? ..... Si / no
15. ¿Tiene alguna lesión en un hueso, músculo, ligamento o articulación que le moleste? ..... Si / no

PREGUNTAS MÉDICAS
16. ¿Tose, jadea o tiene dificultad para respirar durante o después del ejercicio? ..... Si / no
17. ¿Le falta un riñón, un ojo, un testículo (varones), el bazo o cualquier otro órgano? ..... Si / no
18. ¿Tiene dolor en la ingle o en los testículos o un bulto doloroso o una hernia en la zona de la ingle? ..... Si / no
19. ¿Tiene erupciones cutáneas recurrentes o erupciones que van y vienen, incluyendo herpes o estafilococo áureo resistente a la meticilina (MRSA)? ..... Si / no
20. ¿Alguna vez tuvo una conmoción cerebral o lesión en la cabeza que le provocó confusión, dolor de cabeza prolongado o problemas de memoria?..... ..... Si / no
21. ¿Alguna vez tuvo entumecimiento, hormigueo, debilidad en los brazos o las piernas, o no pudo mover los brazos o las piernas después de un golpe o una caída? ..... Si / no
22. ¿Alguna vez se sintió mal cuando hacía ejercicio en el calor? ..... Si / no
23. ¿Usted o alguien de su familia tiene el rasgo o la enfermedad de células falciformes? ..... Si / no
24. ¿Alguna vez tuvo o tiene algún problema con los ojos o la visión? ..... Si / no
25. ¿Le preocupa su peso? ..... Si / no
26. ¿Está intentando o alguien le recomendó subir o bajar de peso? ..... Si / no
27. ¿Sigue alguna dieta especial o evita ciertos tipos de alimentos o grupos de alimentos? ..... Si / no
28. ¿Alguna vez tuvo un trastorno alimentario? ..... Si / no

PREGUNTAS SOBRE LA MENSTRUACIÓN
29. ¿Tuvo alguna vez la menstruación? ..... Si / no
30. ¿Qué edad tenía cuando tuvo su primera menstruación? _____
31. ¿Cuándo tuvo su menstruación más reciente? _____
32. ¿Cuántas menstruaciones tuvo en los últimos 12 meses? _____

Declaración: _____
Por la presente declaro que, a mi leal saber y entender, mis respuestas a las preguntas de este formulario son completas y correctas.

Firma del/de la deportista: _____ Firma del padre/madre o tutor/a: _____ Fecha: ___/_____/_____

2025-2026 SPORTS QUALIFYING PHYSICAL EXAMINATION FORM

Minnesota State High School League

Pages 2-5 of this document should be KEPT on file by the medical provider issuing the physical examination.

Student Name: _____ Birth Date: _____

Follow-Up Questions About More Sensitive Issues:

1. Do you feel stressed out or under a lot of pressure?
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?
3. Do you feel safe?
4. Have you been hit, kicked, slapped, punched, sexually abused, inappropriately touched, or threatened with harm by anyone close to you?
5. Have you ever tried cigarette, cigar, pipe, e-cigarette smoking, or vaping, even 1 or 2 puffs? Do you currently smoke?
6. During the past 30 days, did you use chewing tobacco, snuff, or dip?
7. During the past 30 days, have you had any alcohol drinks, even just one?
8. Have you ever taken steroid pills or shots without a doctor's prescription?
9. Have you ever taken any medications or supplements to help you gain or lose weight or improve your performance?
10. Question "Risk Behaviors" like guns, seatbelts, unprotected sex, domestic violence, drugs, and others.
11. Would you like to have a COVID-19 vaccination?

Notes About Follow-Up Questions:

_____

_____

MEDICAL EXAM

Height_____ Weight _____ BMI (optional) _____ % Body fat (optional)_____ Arm Span _____
Pulse _____ BP _____/_____ (_____/_____)
Vision: R 20/____ L 20/____ Corrected: Y / N Contacts: Y / N Hearing: R____ L____ (Audiogram or confrontation)

Exam	Normal	Abnormal Findings	Initials**
Appearance			
Circle any Marfan stigmata present	→	Kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency	
HEENT			
Eyes			
Fundoscopic			
Pupils			
Hearing			
Cardiovascular*			
Describe any murmurs present (standing, supine, +/- Valsalva)	→		
Pulses (simultaneous femoral & radial)			
Lungs			
Abdomen			
Tanner Staging (optional)	Circle	I II III IV V	
Skin (No HSV, MRSA, Tinea corporis)			
Musculoskeletal			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			
Functional (Double-leg squat test, single-leg squat test, and box drop, or step drop test)			

*Consider ECG, echocardiogram, and/or referral to cardiology for abnormal cardiac history or examination findings ** For Multiple Examiners

Additional Notes: _____

Health Maintenance: ☐ Lifestyle, health, immunizations, & safety counseling ☐ Discussed dental care & mouthguard use ☐ Discussed Lead and TB exposure – (Testing indicated / not indicated) ☐ Eye Refraction if indicated

Provider Signature: _____ Date: _____

Minnesota State High School League

SUPLEMENTO A LOS ANTECEDENTES MÉDICOS DEL DEPORTISTA PARA DEPORTISTAS CON DISCAPACIDAD

El proveedor médico que lleve a cabo esta exploración física debe ARCHIVAR las páginas 2-5 de este documento.

Nombre: _____ Fecha de nacimiento: _____

1. Tipo de discapacidad:
2. Fecha de la discapacidad:
3. Clasificación (si está disponible):
4. Origen de la discapacidad (nacimiento, enfermedad, lesión u otro):
5. Enumere los deportes que está practicando:

6. ¿Utiliza habitualmente algún aparato ortopédico, dispositivo auxiliar o prótesis para las actividades diarias?	S / N
7. ¿Utiliza algún aparato ortopédico o dispositivo auxiliar especial para practicar deportes?	S / N
8. ¿Tiene erupciones, llagas por presión u otros problemas de la piel?	S / N
9. ¿Tiene pérdida auditiva? ¿Utiliza audífonos?	S / N
10. ¿Tiene alguna discapacidad visual?	S / N
11. ¿Utiliza algún dispositivo especial para el funcionamiento de los intestinos o la vejiga?	S / N
12. ¿Tiene ardor o malestar al orinar?	S / N
13. ¿Tuvo disreflexia autonómica?	S / N
14. ¿Alguna vez le diagnosticaron una enfermedad relacionada con el calor o el frío?	S / N
15. ¿Tiene espasticidad muscular?	S / N
16. ¿Tiene convulsiones frecuentes que no pueden controlarse con medicamentos?	S / N

Explique las respuestas afirmativas en este espacio.

_____

_____

_____

Indique si alguna vez tuvo alguna de las siguientes condiciones:

Inestabilidad atlantoaxial	S / N
Evaluación radiográfica (radiografía) para detectar inestabilidad atlantoaxial	S / N
Articulaciones dislocadas (más de una)	S / N
Sangrado fácil	S / N
Agrandamiento del bazo	S / N
Hepatitis	S / N
Osteopenia u osteoporosis	S / N
Dificultad para controlar los intestinos	S / N
Dificultad para controlar la vejiga	S / N
Entumecimiento u hormigueo en brazos o manos	S / N
Entumecimiento u hormigueo en piernas o pies	S / N
Debilidad en brazos o manos	S / N
Debilidad en piernas o pies	S / N
Cambios reciente en la coordinación	S / N
Cambios reciente en la capacidad para caminar	S / N
Espina bífida	S / N
Alergia al látex	S / N

Explique las respuestas afirmativas en este espacio.

_____

_____

_____

Por la presente declaro que, a mi leal saber y entender, mis respuestas a las preguntas de este formulario son completas y correctas.

Firma del/de la deportista: _____ Firma del padre/madre o tutor/a: _____

Fecha: ____/____/_____

Adaptado de la Academia Estadounidense de Médicos de Familia, la Academia Estadounidense de Pediatría, el Colegio Americano de Medicina Deportiva, la Sociedad Médica Estadounidense de Medicina Deportiva, la Sociedad Americana de Ortopedia de Medicina Deportiva y la Academia Estadounidense de Osteopatía.

2025-2026 PI ADAPTED ATHLETICS MEDICAL ELIGIBILITY FORM ADDENDUM

(Use only for Adapted Athletics - PI Division)

Minnesota State High School League

Pages 2-5 of this document should be KEPT on file by the medical provider issuing the physical examination

The MSHSL has competitive interscholastic Physically Impaired (PI) competition. Students who are deemed fit to participate in competitive athletics from a MSHSL sports qualifying exam should meet the criteria below to participate in Adapted Athletics – PI Division.

The MSHSL Adapted Athletics PI Division program is specifically intended for students with physical impairments who are medically eligible to compete in competitive athletics. A student is administratively eligible to compete in the PI Division with one of the two following criteria:

The student must have a diagnosed and documented impairment specified from one of the two sections below:
(Must be diagnosed and documented by a Physician, Physician's Assistant, and/or Advanced Practice Nurse.)

1. _____ Neuromuscular _____ Postural/Skeletal _____ Traumatic

   _____ Growth _____ Neurological Impairment

   Which: _____ affects Motor Function _____ modifies Gait Patterns

   (Optional) _____ Requires the use of prosthesis or mobility device, including but not limited to canes, crutches, walker or wheelchair.

2. _____ Cardio/Respiratory Impairment that is deemed safe for competitive athletics but limits the intensity and duration of physical exertion such that sustained activity for over five minutes at 60% of maximum heart rate for age results in physical distress in spite of appropriate management of the health condition.

   (NOTE:) A condition that can be appropriately managed with appropriate medications that eliminate physical or health endurance limitations WILL NOT be considered eligible for adapted athletics.

Specific exclusions to PI competition:

The following health conditions, without coexisting physical impairments as outlined above, do not qualify the student to participate in the PI Division even though some of the conditions below may be considered Health Impairments by an individual's physician, a student's school, or government agency. This list is not all-inclusive, and the conditions are examples of non-qualifying health conditions; other health conditions that are not listed below may also be non-qualifying for participation in the PI Division.

Attention Deficit Disorder (ADD), Attention Deficit Hyperactive Disorder (ADHD), Emotional Behavioral Disorder (EBD), Autism Spectrum Disorders (including Asperger's Syndrome), Tourette's Syndrome, Neurofibromatosis, Asthma, Reactive Airway Disease (RAD), Bronchopulmonary Dysplasia (BPD), Blindness, Deafness, Obesity, Depression, Generalized Anxiety Disorder, Seizure Disorder, or other similar disorders.

Student Name _____

Provider (PRINT) _____

Provider (SIGNATURE) _____

Date of Exam _____

2025-2026
MINNESOTA STATE HIGH SCHOOL LEAGUE

ANNUAL SPORTS HEALTH QUESTIONNAIRE

Name_____Birth Date_____Today's Date_____Grade____School_____

Date of Last Sports Qualifying Physical Exam (SQPE)_____Sport(s)_____

Address_____Phone_____

Check Yes or No boxes for each question or Circle question numbers for which you cannot answer.

IN THE LAST YEAR, since your last complete Sports Qualifying Physical Exam with your physician or your Year 2 Annual Health Questionnaire, HAVE YOU HAD ANY CHANGES TO THE FOLLOWING QUESTIONS:

Athlete Health Questionnaire

	YES	NO
1. In the last year, has a doctor restricted your participation in sports for any reason without clearing you to return to sports?	☐	☐
IMPORTANT HEART HEALTH QUESTIONS ABOUT YOU IN THE LAST YEAR		
2. In the last year, have you passed out or nearly passed out *during* or *after* exercise?	☐	☐
3. In the last year, have you had discomfort, pain, tightness, or pressure in your chest during exercise?	☐	☐
4. In the last year, does your heart race or skip beats (irregular beats) during exercise?	☐	☐
5. In the last year, do you get light-headed or feel more short of breath than expected during exercise?	☐	☐
6. In the last year, have you had an unexplained seizure?	☐	☐
7. In the last year, has a doctor told you that you have any heart problems?	☐	☐
8. In the last year, has a doctor requested a test for your heart? For example, electrocardiography (ECG) or echocardiogram (ECHO)?	☐	☐
IMPORTANT HEART HEALTH QUESTIONS ABOUT YOUR FAMILY IN THE LAST YEAR		
9. In the last year, has a anyone in your immediate family died suddenly and unexpectedly for no apparent reason?	☐	☐
10. In the last year, has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 (including an unexplained drowning or an unexplained car accident)?	☐	☐
11. In the last year, has anyone in your immediate family had instances of unexplained fainting, seizures, or near drowning?	☐	☐
12. In the last year, has anyone in your immediate family been diagnosed with hypertrophic cardiomyopathy, Marfan Syndrome, arrhythmogenic right ventricular cardiomyopathy, long or short QT Syndrome, Brugada Syndrome, or catecholaminergic polymorphic ventricular tachycardia?	☐	☐
13. In the last year, has anyone in your immediate family under age 35 had a heart problem, pacemaker, or implanted defibrillator?	☐	☐
MEDICAL RISK QUESTIONS IN THE LAST YEAR		
14. In the last year, have you had a head injury or concussion that still has symptoms like continuing headaches, concentration problems or memory problems?	☐	☐
15. In the last year have you become ill while exercising in the heat?	☐	☐
16. In the last year, have you learned that someone in your family has sickle cell trait or disease?	☐	☐
17. In the last year, have you had numbness, tingling, weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?	☐	☐

Parents or Legal Guardians: Please note below any health concerns, medications, or allergies that may be important for the coaches or activities director to know.

_____

_____

I do not know of any existing physical or additional health reason that would preclude participation in sports. I certify that the answers to the above questions are true and accurate, and I approve participation in athletic activities.

Parent or Legal Guardian Signature	Athlete Signature	Date
_____	_____	_____

Activities Director Note: (a YES answer to any of the questions above requires a clearance note from a physician prior to participation.)

_____

_____

SQPE Due_____/_____/_____ **MEDICALLY ELLIGIBLE FOR SPORTS PARTICIPAITON: YES ☐ NO ☐**

Supplemental Mental Health Screening Questions (may be cut from form before submitting)

Over the past 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

(If the sum of responses to questions 1 & 2 or 3 & 4 are ≥3, please see your provider)

Reference: Preparticipation Physical Evaluation (Fifth Edition): AAFP, AAP, AMSSM, AOSSM, AOASM, AAP, 2019. *Revised 4/4/2025*

2025-2026 MSHSL Eligibility Statement (continued)

☐ I further understand that in the case of injury or illness requiring transportation to a health care facility, that a reasonable attempt will be made to contact the parent(s) or guardian(s) in the case of the student-athlete being a minor, but that, if necessary, the student-athlete will be transported via ambulance to the nearest hospital.

☐ By signing this we acknowledge that we have read the information contained in the 2025-2026 MSHSL Eligibility Brochure and Statement.

☐ I/we acknowledge the electronic signature confirms I/we have read and reviewed the information contained in the contents of the Eligibility Brochure and Statement. I/we also acknowledge this electronic signature has the same legal effect, validity, and enforceability as a signature in a non-electronic form.

The student and parent(s)/guardian(s) authorize the release of documents and other pertinent information by the school in order to determine student eligibility. In addition, the student and parent(s)/guardian(s) understand and agree that public information shall include names and pictures of students participating in or attending school events and MSHSL programs.

I am a home school student. **YES** ☐ **NO** ☐ I am an online student. **YES** ☐ **NO** ☐

Student's Printed Name	*Birth Date*	*Grade in School*
Student's Signature		*Date*
Parent's or Guardian's Signature		*Date*

2025-2026 MSHSL Eligibility Statement (continued)

☐ I further understand that in the case of injury or illness requiring transportation to a health care facility, that a reasonable attempt will be made to contact the parent(s) or guardian(s) in the case of the student-athlete being a minor, but that, if necessary, the student-athlete will be transported via ambulance to the nearest hospital.

☐ By signing this we acknowledge that we have read the information contained in the 2025-2026 MSHSL Eligibility Brochure and Statement.

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I am a home school student. **YES** ☐ **NO** ☐ I am an online student. **YES** ☐ **NO** ☐

Student's Printed Name	*Birth Date*	*Grade in School*
Student's Signature		*Date*
Parent's or Guardian's Signature		*Date*