



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





Tolland Middle School

Falcon Way

Tolland, CT 06084

Telephone: 860-870-6860 Fax: 860- 870-5737

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 from 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

"In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the federal relay service at (800) 877-8339; or (800) 845-6136. USDA is an equal opportunity provider and employer."

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) _____	Phone _____
Address _____			
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		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"/>	11. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have an ongoing or chronic illness (Diabetes, Epilepsy, Sickle Cell Disease, Kawasaki's Disease, Marfan's Syndrome or any handicap)?	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear glasses, contacts, or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized overnight?	<input type="checkbox"/>	<input type="checkbox"/>	Do you bruise easily, take a long time to stop bleeding, or have frequent nose bleeds?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had infectious mononucleosis or hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler (for pain or shortness of breath)?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have hearing loss, tubes in your ears, or a perforated eardrum?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever taken any supplements, creatine, steroids, or vitamins to help you gain or lose weight or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have kidney disease or dark brown bloody urine?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have any allergies (for example, to pollen, medicines, food or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have less than 2 kidneys or, in males, less than two testicles?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a rash or hives develop during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have diarrhea more than once a week, or black/bloody bowel movements (stools)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have lump(s) in the armpit or groin?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you ever had a sprain, strain, or swelling after injury?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have you broken or fractured any bones or dislocated any joints?	<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 had any other problems with pain or swelling in muscles, tendons, bones, or joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, check appropriate box and explain below:		
Have you had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip
Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh
Has any family member or relative died of heart problems or of sudden death before age 50?	<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)?	<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
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Upper arm	<input type="checkbox"/> Foot	
7. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	13. Do you want to weigh more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	Have you lost or gained more than 10 pounds in the past year?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	Are you on a special diet?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had numbness or tingling in your arms, hands, legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>	14. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a stinger, burner or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	15. Record the dates of your most recent immunizations (shots) for:		
Have you had a neck, spine or low back injury or pain?	<input type="checkbox"/>	<input type="checkbox"/>	tetanus _____		
8. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B _____		
9. Do you cough, wheeze, or have trouble breathing during or after activity?	<input type="checkbox"/>	<input type="checkbox"/>	Chickenpox _____		
Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>	Meningococcus _____		
Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>			
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)?	<input type="checkbox"/>	<input type="checkbox"/>	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 _____

NORMAL	ABNORMAL FINDINGS	INITIALS*
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MEDICAL

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			

*Initials of physician or other qualified health care provider

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

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