

2021-2022

Central Middle School



Cheerleading

Application

Go Vikings!



CMS Cheerleader Application

Due Date: **Wednesday, April 14, 2021**

Turn in to CMS office or email to: holleyrg@gatescountyschools.net

Student Name (Please Print) _____

Current Grade Level (check one): 6th ___ 7th ___ 8th ___

Home Address: _____

Home Phone: _____ Cell Phone: _____

Student Email Address: _____

Parent/Guardian Name (Please Print): _____

Cell Phone: _____ Work Number: _____

Email: _____

Parent/Guardian Name (Please Print): _____

Cell Phone: _____ Work Number: _____

Email: _____

Please check all that you can do proficiently.

Skills: Cartwheel ___ Round-off ___ Split ___ Front Handspring ___ Back Handspring ___

Stunting: Base _____ Flyer _____ Back Spot _____

Cheer Experience: List Squad _____

Allstar_____

Community Squad_____

I have read and understand the preliminary expectations. I understand I will receive a Cheerleader Handbook with a complete listing of all guidelines and rules once my completed application has been submitted and approved. I understand that I must have all forms submitted on time to participate fully.

Parent/Guardian Signature(s): _____



_____ Date _____

Student Signature: _____ **Date:** _____

To: Parents/Guardians, Students

Fr: Coach Reba Green-Holley

Re: 2021-2022 Cheerleader Try-Outs

Cheerleader try-outs for the 2021-2022 Season will be held **Monday, April 19 – 23** from **3:00 – 5:30** at Central Middle School gym.

Requirements – Due Wednesday, April 14

Completed Application and Forms

Physical –Can use current one from 2020-2021 school year

Concussion Form – Can use current one from 2020-2021 school year

Rankone info entered - <https://rankonesport.com/content/>

Passing Grades 5 out of 6 classes

Student is required to attend all practices and actual try-outs will be held on Friday. Cheer team will be announced. Parent Meeting: Friday, April 23, immediately following try-outs.

Try-Out Dress Code and Items: T-shirt with no Cheer logos, Shorts or Leggings, Tennis Shoes, No Show Socks, Mask, Water Bottle and Large Towel. Must remove all jewelry and hair must be secured away from face. Good foundation support, if needed.

Please be aware of and discuss with your child the time and energy it takes to be an effective student leader here at Central Middle School. We expect each cheerleader to set a good example at all times. This opportunity will help students form friendships, improve communication skills as well as develop leadership skills that will prove to be beneficial later in life. During the school year practices will be held four days a week in conjunction with football and basketball games.

We look forward to working with you and your child!

Contact Info:

Coach Reba Green-Holley

Email: holleyrg@gatescountyschools.net

252-287-6991 C | 252-357-0961 H

Coach Monique Gatling

Email: nquire07@gmail.com

252-319-0717 C

Viking Pride,
Reba Green-Holley
Cheer Coach

Monique Gatling
Assistant Coach

NORTH CAROLINA HIGH SCHOOL ATHLETIC ASSOCIATION SPORT PREPARTICIPATION EXAMINATION FORM

Student Athlete's Name: _____ **Age:** _____ **Sex:** _____

*This is a screening examination for participation in sports. **This does not substitute for a comprehensive examination with your child's regular physician where important preventive health information can be covered.***

Student-Athlete's Directions: Please review all questions with your parent or legal custodian and answer them to the best of your knowledge.

Parent/Legal Custodian Directions: Please assure that all questions are answered to the best of your knowledge. If you do not understand or are unsure about the answer to a question please ask your doctor. Not disclosing accurate information may put your child at risk during sports activity.

Physician's Directions: We recommend carefully reviewing these questions and clarifying any "Yes" or "Unsure" answers.

Explain "Yes" or "Unsure" answers in the space provided below or on an attached separate sheet if needed.	Yes	No	Unsure
1. Does the student-athlete have any chronic medical illnesses [diabetes, asthma (exercise asthma), kidney problems, etc.]? List:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Is the student-athlete presently taking any medications or pills?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Does the student-athlete have any allergies (medicine, bees or other stinging insects, latex)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the student-athlete have the sickle cell trait?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Has the student-athlete ever had a head injury, been knocked out, or had a concussion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Has the student-athlete ever had a heat injury (heat stroke) or severe muscle cramps with activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has the student-athlete ever passed out or nearly passed out DURING exercise, emotion or startle?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Has the student-athlete ever fainted or passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Has the student-athlete had extreme fatigue (been really tired) with exercise (different from other children)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Has the student-athlete ever had trouble breathing during exercise, or a cough with exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Has the student-athlete ever been diagnosed with exercise-induced asthma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Has a doctor ever told the student-athlete that they have high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Has a doctor ever told the student-athlete that they have a heart infection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Has a doctor ever ordered an EKG or other test for the student-athlete's heart, or has the athlete ever been told they have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Has the student-athlete ever had discomfort, pain, or pressure in his chest during or after exercise or complained of their heart "racing" or "skipping beats"?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Has the student-athlete ever had a seizure or been diagnosed with an unexplained seizure problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Has the student-athlete ever had a stinger, burner or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Has the student-athlete ever had any problems with their eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Place a check beside each body part that the student-athlete has ever sprained/strained, dislocated, fractured, broken had repeated swelling in or had any other type of injury to any bones or joints? <input type="checkbox"/> Head <input type="checkbox"/> Shoulder <input type="checkbox"/> Thigh <input type="checkbox"/> Neck <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Chest <input type="checkbox"/> Hip <input type="checkbox"/> Forearm <input type="checkbox"/> Shin/calf <input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Ankle <input type="checkbox"/> Hand <input type="checkbox"/> Foot Other: _____			
20. Has the student-athlete ever had an eating disorder, or are there concerns about his/her eating habits or weight?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Has the student-athlete ever been hospitalized or had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Has the student-athlete had a medical problem or injury since their last evaluation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. (Place a check beside each statement that applies to the student-athlete, elaborate in the space provided below). <input type="checkbox"/> 1. Has the student-athlete had little interest or pleasure in doing things? <input type="checkbox"/> 2. Has the student-athlete been feeling down, depressed, or hopeless for more than 2 weeks in a row? <input type="checkbox"/> 3. Has the student-athlete been feeling bad about himself/herself that they are a failure, or let their family down? <input type="checkbox"/> 4. Has the student-athlete had thoughts that he/she would be better off dead or hurting themselves?			
FAMILY HISTORY			
24. Has any family member had a sudden, unexpected death before age 50 (including from sudden infant death syndrome [SIDS], car accident, drowning)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Has any family member had unexplained heart attacks, fainting or seizures?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Does the athlete have a father, mother or brother with sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Explain "yes" or "unsure" answers here: _____

By signing below, I agree that I have reviewed and answered each question above. Every question is answered completely and is correct to the best of my knowledge. Furthermore, as parent or legal custodian, I give consent for this examination and give permission for my child to participate in sports.

Signature of parent/legal custodian: _____ Date: _____ Phone #: _____

Signature of Athlete: _____ Date: _____

Student-Athlete's Name: _____ Age: _____ Date of Birth: _____

Height: _____ Weight: _____ BP _____ (_____ % ile) / _____ (_____ % ile) Pulse: _____

Vision: R 20/ _____ L 20/ _____ Corrected: Y N

Physical Examination (Below Must be Completed by Licensed Physician, Nurse Practitioner or Physician Assistant)

These are required elements for all examinations			
	NORMAL	ABNORMAL	ABNORMAL FINDINGS
PULSES			
HEART			
LUNGS			
SKIN			
NECK/BACK			
SHOULDER			
KNEE			
ANKLE/FOOT			
Other Orthopedic Problems			

Optional Examination Elements – Should be done if history indicates

HEENT			
ABDOMINAL			
GENITALIA (MALES)			
HERNIA (MALES)			

Clearance:

- A. Cleared
- B. Cleared after completing evaluation/rehabilitation for: _____
- *** C. Medical Waiver Form must be attached (for the condition of: _____)
- D. Not cleared for: Collision Contact
 Non-contact _____ Strenuous _____ Moderately strenuous _____ Non-strenuous

Due to: _____

Additional Recommendations/Rehab Instructions: _____

Name of Physician/Extender: _____ (Please print)

Signature of Physician/Extender: _____ MD DO PA NP (Please circle)

(Both signature and circle of designated degree required)

Date of Examination: _____

Address: _____

Phone: _____

Physician Office Stamp

(*** The following are considered disqualifying until appropriate medical and parental releases are obtained: post-operative clearance, acute infections, obvious growth retardation, uncontrolled diabetes, severe visual or auditory impairment, pulmonary insufficiency, organic heart disease or Stage 2 hypertension, enlarged liver or spleen, a chronic musculoskeletal condition that limits ability for safe exercise/sport (i.e. Klippel-Feil anomaly, Sprengel's deformity), history of uncontrolled seizures, absence of/ or one kidney, eye, testicle or ovary, etc.)

This form is approved by the North Carolina High School Athletic Association Sports Medicine Advisory Committee and the NCHSAA Board of Directors.

CONCUSSION

INFORMATION FOR *STUDENT-ATHLETES & PARENTS/LEGAL CUSTODIANS*

What is a concussion? A concussion is an injury to the brain caused by a direct or indirect blow to the head. It results in your brain not working as it should. It may or may not cause you to black out or pass out. It can happen to you from a fall, a hit to the head, or a hit to the body that causes your head and your brain to move quickly back and forth.

How do I know if I have a concussion? There are many signs and symptoms that you may have following a concussion. A concussion can affect your thinking, the way your body feels, your mood, or your sleep. Here is what to look for:

Thinking/Remembering	Physical	Emotional/Mood	Sleep
Difficulty thinking clearly	Headache	Irritability-things bother you more easily	Sleeping more than usual
Taking longer to figure things out	Fuzzy or blurry vision	Sadness	Sleeping less than usual
Difficulty concentrating	Feeling sick to your stomach/queasy	Being more moody	Trouble falling asleep
Difficulty remembering new information	Vomiting/throwing up	Feeling nervous or worried	Feeling tired
	Dizziness	Crying more	
	Balance problems		
	Sensitivity to noise or light		

Table is adapted from the Centers for Disease Control and Prevention (<http://www.cdc.gov/concussion/>)

What should I do if I think I have a concussion? If you are having any of the signs or symptoms listed above, you should tell your parents, coach, athletic trainer or school nurse so they can get you the help you need. If a parent notices these symptoms, they should inform the school nurse or athletic trainer.

When should I be particularly concerned? If you have a headache that gets worse over time, you are unable to control your body, you throw up repeatedly or feel more and more sick to your stomach, or your words are coming out funny/slurred, you should let an adult like your parent or coach or teacher know right away, so they can get you the help you need before things get any worse.

What are some of the problems that may affect me after a concussion? You may have trouble in some of your classes at school or even with activities at home. If you continue to play or return to play too early with a concussion, you may have long term trouble remembering things or paying attention, headaches may last a long time, or personality changes can occur. Once you have a concussion, you are more likely to have another concussion.

How do I know when it's ok to return to physical activity and my sport after a concussion? After telling your coach, your parents, and any medical personnel around that you think you have a concussion, you will probably be seen by a doctor trained in helping people with concussions. Your school and your parents can help you decide who is best to treat you and help to make the decision on when you should return to activity/play or practice. Your school will have a policy in place for how to treat concussions. You should not return to play or practice on the same day as your suspected concussion.

You should not have any symptoms at rest or during/after activity when you return to play, as this is a sign your brain has not recovered from the injury.

This information is provided to you by the UNC Matthew Gfeller Sport-Related TBI Research Center, North Carolina Medical Society, North Carolina Athletic Trainers' Association, Brain Injury Association of North Carolina, North Carolina Neuropsychological Society, and North Carolina High School Athletic Association.

Student-Athlete & Parent/Legal Custodian Concussion Statement

**If there is anything on this sheet that you do not understand, please ask an adult to explain or read it to you.*

Student-Athlete Name: _____

This form must be completed for each student-athlete, even if there are multiple student-athletes in each household.

Parent/Legal Custodian Name(s): _____

- We have read the *Student-Athlete & Parent/Legal Custodian Concussion Information Sheet*.
If true, please check box.

After reading the information sheet, I am aware of the following information:

Student-Athlete Initials		Parent/Legal Custodian Initials
	A concussion is a brain injury, which should be reported to my parents, my coach(es), or a medical professional if one is available.	
	A concussion can affect the ability to perform everyday activities such as the ability to think, balance, and classroom performance.	
	A concussion cannot be "seen." Some symptoms might be present right away. Other symptoms can show up hours or days after an injury.	
	I will tell my parents, my coach, and/or a medical professional about my injuries and illnesses.	N/A
	If I think a teammate has a concussion, I should tell my coach(es), parents, or medical professional about the concussion.	N/A
	I will not return to play in a game or practice if a hit to my head or body causes any concussion-related symptoms.	N/A
	I will/my child will need written permission from a medical professional trained in concussion management to return to play or practice after a concussion.	
	Based on the latest data, most concussions take days or weeks to get better. A concussion may not go away right away. I realize that resolution from this injury is a process and may require more than one medical evaluation.	
	I realize that ER/Urgent Care physicians will not provide clearance if seen right away after the injury.	
	After a concussion, the brain needs time to heal. I understand that I am/my child is much more likely to have another concussion or more serious brain injury if return to play or practice occurs before concussion symptoms go away.	
	Sometimes, repeat concussions can cause serious and long-lasting problems.	
	I have read the concussion symptoms on the Concussion Information Sheet.	

Signature of Student-Athlete

Date

Signature of Parent/Legal Custodian

Date

Central Middle School
362 US Hwy 158 West
Gatesville, NC 27938

Medical Release Form

_____ has my permission to
(Student Name)
participate in _____ at Central Middle School and to
(Sport)
receive medical attention for any injury.

Parent/Guardian Name (Please Print) _____

Home Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Insurance Company _____ **Policy #** _____

Family Physician: _____ Physicians Number: _____

Child's Allergies: _____

Additional Medical Condition(s) that the Coach should know about?:

IN CASE I CAN NOT BE REACHED, EITHER OF THE FOLLOWING PEOPLE ARE DESIGNATED:

Name: _____ Phone Number _____

Relationship to Athlete: _____

Name: _____ Phone Number _____

Relationship to Athlete: _____

.In case of emergency, I give permission for my child to receive emergency care

Parent/Guardian Signature(s): _____

_____ Date _____