



4525 Highway 109
Eureka, MO 630255
636.733.3137 Phone
636.733.8813 Fax

Eureka High School

Dear Parent/Guardian,

Your child has expressed interest in becoming an Athletic Training Student Aide through the HOSA program at Eureka High School. This program will offer students interested in sports medicine or any other health care profession, the unique opportunity to work with the certified athletic trainer on the sidelines at games, and in the athletic training room (ATR) gaining valuable medical knowledge in first aid, and recognition, treatment, and rehabilitation of sports related injuries. The Athletic Training Student aid program will encourage responsibility, foster time management skills, and provide an opportunity for enhanced personal growth.

Although this program will be done after school, academics will remain the top priority for every student. We request your assistance in emphasizing this priority. Please review the ATHLETIC TRAINING STUDENT AIDE GUIDELINES with your child and then sign the permission slip at the end of this letter. If you have any questions please feel free to call at any time. Thank you for your support.

Sincerely,

Sharon Henderson, M.Ed., LAT, ATC
Eureka High School
Cell: 314-323-3392
Office: ext. 43204

I have read the guidelines and give my permission for _____
to participate as an athletic training student.

Parent/Guardian Signature

Date

Department of Activities

Gregg Cleveland, Director of Activities
ClevelandGregg@rsdmo.org
Cindy Hirsch, Secretary
HirschCindy@rsdmo.org
Sharon Henderson, Athletic Trainer
HendersonSharon@rsdmo.org

Athletic Training Student Aide Guidelines and Policies

The Athletic Training Student Aide:

1. Must maintain a minimum 3.0 gpa to be eligible.
2. Is expected to be prompt, professional, and reliable.
3. Will wear appropriate clothing (no short shorts, no cut off shirts, no tank tops, no shirts with vulgar language etc.) and be respectful to all
4. Agrees to show up and stay for duration of time signed up for
5. Is encouraged to become certified in advanced first aid and CPR (Optional).
6. Will cover the training room and/or athletic team or event only with the Certified Athletic Trainer's (ATC) permission.
7. Will only learn the taping and wrapping techniques approved by the ATC.
8. May not begin any treatment process (i.e. ice or stretch) without direct supervision of the ATC.
9. Is not allowed to diagnose athletic injuries. Evaluations should only be done by the ATC.
10. Will NOT, under any circumstance, transport an injured or ill athlete.
11. Will NOT issue any medications, including over-the-counter medications.
12. Will ask the ATC questions when in doubt about what they're doing.
13. **Is NOT to discuss an athlete's illness or injury with anyone except involved medical personnel.**
14. Preference may be given to students who do not participate in sports during the season in which they wish to volunteer.

Application for Athletic Training Student Aide

Name: _____ Grade: _____

GPA: _____ Sports played at EHS: _____

Student E-Mail Address: _____

Sports Season Interested in Volunteering (Circle all that apply)

Fall

Winter

Spring

Days of the Week you would be Available (Circle all that Apply): M T W TH F

Please list any experiences which you believe may be of benefit in the space below:

Please provide explain why you would to be considered to be a student athletic training aide and/or what you hope to gain from this experience:

Parent Contact Information

Mother Name: _____ Phone: _____

Father Name: _____ Phone: _____

**Please return completed application to the
Athletic Training Room (Across from Gym B) ASAP**