

This form is to help assist you with keeping track of the information required to turn in order to participate in tryouts. Please be sure all the following have been completed by the due date, April 23, 2021

CHEER PACKET CHECKLIST

- ☐ Checklist (signed and dated)
- ☐ Information Sheet (retained by you)
- ☐ Student/ Parent Concussion Awareness Form (signed and dated)
- ☐ Parent Permission Form (signed and dated)
- ☐ Athlete Roster (completely filled out, signed and dated)
- ☐ Copy of Insurance Card (included by you)
- ☐ Westside High School Cheer Registration Form (completely filled out)
- ☐ Copy of Current Physical (signed and dated)
- ☐ Clearance Form (signed and dated)
- ☐ Richmond County School System Interscholastic CONTRACT for Parents and Student-Athletes
- ☐ Copy of most recent report card
- ☐ Teacher Recommendations (3) (sealed in an envelope)

*** *Failure to complete any one of the above items by April 23rd will result in the inability of the applicant to participate in clinics or tryouts. ****

I agree that this packet includes all the above completed items.

Print Name

Upcoming grade level

Student Signature

Date

Email

Alternate Email

WHS Cheerleading Tryout Information Sheet

Westside High School Patriots Cheerleading team strives to build the best cheerleading program with squads that excel in academics, support for WHS athletic teams, and school spirit.

Tryout are CLOSED and MANDATORY sessions

When: May 3-7, 2021

Where: New Gym

Who: Current Students	3:00 PM — 4:30 PM
Rising Freshman	4:30 PM – 6:00 PM

The only allowances that will be made during tryout week will be for academic reasons and spring sports participants. Keeping this in mind, please do not commit to other events that may conflict with tryouts. Please give serious thought to any other obligation you already have. If these require out-of-town engagements or conflict with practices, it may be necessary to make a choice.

Tryout Procedure:

PLEASE NOTE: We will be implementing a new process. There will be two (2) cuts for tryouts. Everyone will try out Monday – Wednesday, May 3rd- 5th. An initial cut would be made that evening. Participants that make it through the first cut will receive a call back for Thursday, May 6th- Friday, May 7th. A final decision will be made on May 7th and participants who make the team will have their number placed on the JV/Varsity webpage: Tryouts will begin PROMPTLY 3:00. You will have a scheduled time slot for final cut tryouts.

You will be taught cheers, one dance, the fight song, and jumps. You will also be responsible for creating your own chant to perform during tryouts. Stunting and tumbling will not be taught at tryouts. If you choose to tumble for the actual tryout, you cannot have a spotter.

- o Mandatory Dress: Appropriate Shorts, shirts, and athletic shoes must be worn at all times.
- o Masks must be worn at all times during conditioning and tryouts!
- o NO JEWELRY!
- o Hair must be pulled back away from face in one ponytail.
- o Mandatory tryout practices will be held in the New Gym. Roll will be taken.

- o You must be ready to begin practice at 3:00 PM! Promptness everyday will be expected. Lateness will be documented.
- o Participants will be sectioned off according to COVID-19 requirements.

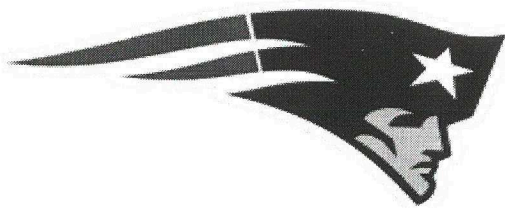
Judging

Applicants will be judged on the following:

- o Teacher Recommendations
- o Multiple cheers
- o Dance routine
- o Cheer /Chant performance
- o Strength
- o Endurance
- o Attitude

We sincerely hope to continue traditions set by previous squads while improving the quality of the program. If you have any questions, please contact Ms. Katrina Stone (stoneka@richmond.k12.ga.us) or Ms. Marsha Gibson (gibsoma@richmond.k12.ga.us). Thanks for your interest in the WHS Cheerleading Program.

GO PATS!



Georgia High School Association

Student/Parent Concussion Awareness Form

SCHOOL: WESTSIDE HIGH SCHOOL

DANGERS OF CONCUSSION

Concussions at all levels of sports have received a great deal of attention and a state law has been passed to address this issue. Adolescent athletes are particularly vulnerable to the effects of concussion. Once considered little more than a minor "ding" to the head, it is now understood that a concussion has the potential to result in death, or changes in brain function (either short-term or long-term). A concussion is a brain injury that results in a temporary disruption of normal brain function. A concussion occurs when the brain is violently rocked back and forth or twisted inside the skull as a result of a blow to the head or body. Continued participation in any sport following a concussion can lead to worsening concussion symptoms, as well as increased risk for further injury to the brain, and even death.

Player and parental education in this area is crucial — that is the reason for this document. Refer to it regularly. This form must be signed by a parent or guardian of each student who wishes to participate in GHSA athletics. One copy needs to be returned to the school, and one retained at home.

COMMON SIGNS AND SYMPTOMS OF CONCUSSION

- Headache, dizziness, poor balance, moves clumsily, reduced energy level/tiredness • Nausea or vomiting
- Blurred vision, sensitivity to light and sounds
- Fogginess of memory, difficulty concentrating, slowed thought processes, confused about surroundings or game assignments
- Unexplained changes in behavior and personality
- Loss of consciousness (NOTE: This does not occur in all concussion episodes.)

BY-LAW 2.68: GHSA CONCUSSION POLICY: In accordance with Georgia law and national playing rules published by the National Federation of State High School Associations, any athlete who exhibits signs, symptoms, or behaviors consistent with a concussion shall be immediately removed from the practice or contest and shall not return to play until an appropriate health care professional has determined that no concussion has occurred. (NOTE: An appropriate health care professional may include licensed physician (MD/DO) or another licensed individual under the supervision of a licensed physician, such as a nurse practitioner, physician assistant, or certified athletic trainer who has received training in concussion evaluation and management.

a) No athlete is allowed to return to a game or a practice on the same day that a concussion (a) has been diagnosed, OR (b) cannot be ruled out.

b) Any athlete diagnosed with a concussion shall be cleared medically by an appropriate health care professional prior to resuming participation in any future practice or contest. The formulation of a gradual return to play protocol shall be a part of the medical clearance.

By signing this concussion form, I give _____ High School permission to transfer this concussion form to the other sports that my child may play. I am aware of the dangers of concussion and this signed concussion form will represent myself and my child during the 2021-2022 school year. This form will be stored with the athletic physical form and other accompanying forms required by the _____ School System,

I HAVE READ THIS FORM AND I UNDERSTAND THE FACTS PRESENTED IN IT.

Student Name (Printed)

Student Name (Signed)

Date

Parent Name (Printed)

Parent Name (Signed)

Date

**PARENT PERMISSION
FOR STUDENT ATHLETIC PARTICIPATION**

Dear Parent(s) or Guardians(s):

The school's athletic program is an integral part of the curriculum, and school personnel have devoted great effort to assure that participating students are protected in every way possible. However, participation in athletics includes a risk of injury which may range in severity from minor to long-term catastrophic, including paralysis and death.

Participants have the responsibility to help reduce the chance of injury. Participants must obey all safety rules and regulations, participate in all required physicals, report all physical problems to the coach or athletic trainer, follow a proper conditioning program and inspect personal protective equipment daily. Proper execution of skill techniques must be followed for every sport.

It is the policy of the Richmond County School System that all athletic participants, other than football, provide either proof of insurance, purchase the student accident insurance policy that is sanctioned by the Board, or sign a military waiver, provided by the school for military dependents. Participants in football must either provide proof of insurance, sign a military waiver, or purchase the football policy carried by the student accident insurance company. The school's athletic program is not authorized to extend public funds for injuries; thus, it will be the responsibility of the parent or guardian to pay any costs for any injury, which is not covered by insurance.

PLEASE INITIAL EACH OF THE FOLLOWING STATEMENTS TO SHOW THAT THE STATEMENT HAS BEEN READ, UNDERSTOOD AND APPROVED:

_____ I consent to have my son/daughter represent his/her school in approved athletic activities except those activities excluded by the examining doctor.

_____ I grant permission for my son/daughter to accompany any school team of which he/she is a member to out-of-town trips. The athlete will be transported to and from all events in school approved vehicles. Parent/Guardians wishing to have their son/daughter with them returning from an event must make written arrangement with the coach.

_____ In the event of an emergency requiring medical attention, I understand every attempt will be made to contact me. In case I cannot be reached, I grant permission for any immediate treatment deemed necessary by the attending physician and transfer of my son/daughter to a qualified medical facility. This authorization does not cover major surgery unless formally decreed prior to surgery by two licensed physicians or dentists.

_____ I agree not to hold the school or anyone acting on its behalf responsible for any injury occurring to my son/daughter in the proper course of such athletic activities or travel.

_____ I acknowledge and accept that there are risks of physical injury involved in athletic participation which may result in permanent paralysis, mental disability, and death.

Date: _____ Signature: _____
(Parent/Legal Guardian)

Date: _____ Signature: _____
(Parent/Legal Guardian)

ATHLETE ROSTER

Sport: _____

Name: _____ Birthdate: _____

Sex: [M] [F] Grade: _____

Address: _____

Home Phone #: _____

Name of Parent/Guardian: _____

Address (if different from above): _____

Home Phone #: (Mother) _____ (Father) _____

Business Phone #: (Mother) _____ (Father) _____

PERSON OTHER THAN PARENT/GUARDIAN TO CONTACT IN CASE OF EMERGENCY:

Name: _____ Relation: _____

Address: _____

Phone#: (Home) _____ (Business) _____

FAMILY PHYSICIAN INFORMATION:

Physician Name: _____ Specialty: _____

Address: _____

Phone #: (Office) _____ (Emergency) _____

INSURANCE COMPANY INFORMATION:

Primary: _____ Policy #: _____

Secondary: _____ Policy #: _____

Specific medication, allergies, medical problems of the athlete:

INSURANCE WAIVER

TO: COUNTY BOARD OF EDUCATION OF RICHMOND COUNTY
864 BROAD STREET
AUGUSTA, GEORGIA 30901

Gentlemen:

I am the parent(s) or legal guardian of _____
who is a student at _____ school.

I understand the school board adopted a policy in August 1979 requiring all students who participate in interscholastic athletics to purchase accident insurance offered at the school. I further understand this insurance is to help defray the costs of any medical expenses my child may incur as a result of his/her school athletic program.

Therefore, I request a waiver of the school board requirement that I purchase accident insurance for the child named above.

In consideration for which I do hereby agree to release, covenant not to institute any suit or claim, waive, indemnify, hold harmless, release and discharge the County Board of Education of Richmond County, its individual members, agents, employees, and representatives, from any responsibilities of any kind whatsoever as a result of the granting of this waiver or as a result of any injuries that my child (ward) may receive or sustain in the athletic program at his/her school.

Yours very truly,

(Date)

WESTSIDE HIGH SCHOOL CHEERLEADING REGISTRATION FORM

PARTICIPANT _____ SPORT: FOOTBALL/BASKETBALL/BOTH

Email _____ Age _____ DOB _____

Cell # _____ HOME# _____ WORK# _____

Current School _____ Current Grade Level _____

Lives with: Mother _____ Father _____ Legal Guardian _____

MOTHER'S NAME: _____

Email _____

Home Phone _____ Cell _____ Work _____

Address _____ City _____ Zip _____

FATHER'S NAME: _____

Email _____

Home Phone _____ Cell _____ Work _____

Address _____ City _____ Zip _____

LEGAL GUARDIAN'S NAME: _____

Email _____

Home Phone _____ Cell _____ Work _____

Address _____ City _____ Zip _____

Emergency Contact _____ Phone number(s) _____

Participant's Doctor _____

Phone _____

Insurance Company _____ Policy # _____

Current medication or supplements

Allergies to medicines

Further medical information or psychological disabilities

■ PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, or other): _____

List past and current medical conditions. _____

Have you ever had surgery? If yes, list all past surgical procedures. _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional). _____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects). _____

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (check box next to appropriate number)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Not being able to stop or control worrying	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Feeling down, depressed, or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

(A sum of ≥ 3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS		Yes	No
(Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)			
1. Do you have any concerns that you would like to discuss with your provider?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Has a provider ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have any ongoing medical issues or recent illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEART HEALTH QUESTIONS ABOUT YOU		Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has a doctor ever told you that you have any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)		Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		Yes	No
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

■ PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

- Consider additional questions on more-sensitive issues.
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: _____	Weight: _____	
BP: _____ / _____ (_____ / _____)	Pulse: _____	Vision: R 20/____ L 20/____ Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance <ul style="list-style-type: none"> Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency) 	<input type="checkbox"/>	
Eyes, ears, nose, and throat <ul style="list-style-type: none"> Pupils equal Hearing 	<input type="checkbox"/>	
Lymph nodes	<input type="checkbox"/>	
Heart ^a <ul style="list-style-type: none"> Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) 	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	
Skin <ul style="list-style-type: none"> Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis 	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck	<input type="checkbox"/>	
Back	<input type="checkbox"/>	
Shoulder and arm	<input type="checkbox"/>	
Elbow and forearm	<input type="checkbox"/>	
Wrist, hand, and fingers	<input type="checkbox"/>	
Hip and thigh	<input type="checkbox"/>	
Knee	<input type="checkbox"/>	
Leg and ankle	<input type="checkbox"/>	
Foot and toes	<input type="checkbox"/>	
Functional <ul style="list-style-type: none"> Double-leg squat test, single-leg squat test, and box drop or step drop test 	<input type="checkbox"/>	

^a Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

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■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

☐ Medically eligible for certain sports

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: _____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can 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 medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: _____

Medications: _____

Other information: _____

Emergency contacts: _____

■ PREPARTICIPATION PHYSICAL EVALUATION ATHLETES WITH DISABILITIES FORM: SUPPLEMENT TO THE ATHLETE HISTORY

Name: _____ Date of birth: _____

1. Type of disability:		
2. Date of disability:		
3. Classification (if available):		
4. Cause of disability (birth, disease, injury, or other):		
5. List the sports you are playing:		
	Yes	No
6. Do you regularly use a brace, an assistive device, or a prosthetic device for daily activities?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed as having a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "Yes" answers here.

Please indicate whether you have ever had any of the following conditions:

	Yes	No
Atlantoaxial instability		
Radiographic (x-ray) evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "Yes" answers here.

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

■ PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

Name _____ Sex ☐ M ☐ F Age _____ Date of birth _____

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

☐ Not cleared

☐ Pending further evaluation

☐ For any sports

☐ For certain sports _____

Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is 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/guardians).

Name of physician (print/type) _____ Date _____

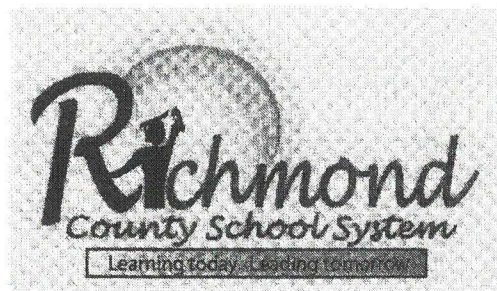
Address _____ Phone _____

Signature of physician _____ MD or DO

EMERGENCY INFORMATION

Allergies _____

Other information _____



Richmond County School System Interscholastic **CONTRACT** for Parents and Student-Athletes

1. I understand that each participating student in athletics, extracurricular, co-curricular and interscholastic activities is expected to maintain at least a 75 average in order to remain eligible. I also understand that progress reports will be done every three (3) weeks and I must sign the report and return to the school. I also understand that if my child does not maintain academic achievement, that he/she will be removed from participation until such grades have improved and academic expectations and requirements have been met.
2. I understand that my child is expected to attend all practices, rehearsals, meetings and events, to arrive promptly and to remain throughout the scheduled hours. I also agree to provide a written excuse for missed practices and pick up my child after practices, rehearsals, meetings and events have ended.
3. I understand that my child is to cooperate and conduct him or herself with Administrators, teachers, coaches, spectators, officials and team members in a manner showing respect to all persons.
4. I understand that my child must adhere to all school policies and the policies of the Richmond County Board of Education.
5. I understand that my child must maintain the highest standards of honesty and integrity while representing the school and the school system of Richmond County.
6. I understand that my child is to respect and care for all equipment and supplies issued by the Richmond County School System. I also understand that I am held financially responsible for any theft, damage or loss of any of the equipment or supplies issued to my child by the Richmond County School System.

The privilege of representing a school rests upon the personal responsibility of the child and the parent. In consideration of the County Board of Education of Richmond County offering athletics, extracurricular, co-curricular, and interscholastic activities and selecting my child as a member, I promise that my child will attend school regularly, maintain high academic standards, and be cooperative and respectful of others. This contract is for the _____ school year.

This contract becomes effective this _____ day of _____ 20_____.

Signature of parent or guardian

Signature of student

Teacher Recommendation Form

*****This is for teacher use only.*****

Teachers, I ask that you are very honest on this form. Please fill out this form, seal it in an envelope and return it to the student to include in their packet. It **MUST BE SEALED**. WHS Cheer wants to have students who are very dedicated inside and outside of the classroom.

Students Name: _____

Teachers Name: _____

What grade level did you have the student? _____

What grade does the student currently have in your class? _____

What is attribute that this student brings to his or her school and how do they show it?

Please describe the student's attitude in class and if you know the student outside of class.

Any other comments as to why this student would make a great WHS Cheerleader? _____

Teacher's Signature _____

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Teacher's Signature _____