Spring 2019 Sports Form

Charles Finney High School

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***** A current Physical Examination and permission from parents are needed to play sports. *****

ALL COMPLETED SPORTS PAPERWORK SHOULD BE SUBMITTED TO THE NURSES IN THE HEALTH OFFICE *AT THE SCHOOL YOU ATTEND…*
(Regardless of which team you intend to play for)
***** See contact information above *****

CHECKLIST FOR STUDENT-ATHLETES

(Please read instructions below on how to meet the requirements for participation in our athletic program)

1.___ Student-Athletes must have a valid physical examination **on file in the Health Office at the school you attend.** New York State regulations specify that physical exams are only valid for a period of one year (twelve continuous months to the last day of the month it was given). **(To be eligible to participate in Spring 2019 Sports, physical exams must be dated within one year of the month your sport begins).** If you are unsure of when your physical expires, check with your school nurse **as soon as possible.** We suggest that you staple a copy of your current physical to your paperwork if you have it.

2.___ The **Athletic Program Permission Slip/Medical Recertification Form**

Please Note:

- A **NEW** permission slip is needed before **EACH** sports season.
- Forms must be **completely filled out** and signed by a parent ***AND*** the student ***NO EARLIER than 30 days before the first practice or try-out date (see the Athletics Website)***, **and then turned in to your school nurse at the school you attend**.
- Forms dated or handed in prior to that time will be **INVALID** and **NOT** accepted.
- **DEADLINE: All forms are due in the Nurses' Office at least 1 week prior to the first practice or try-out date.**

3.___ **We ask that all permission forms be submitted directly to your school's Health Office.** Doctor's notes stating that the student is cleared to participate in sports or listing any specific restrictions are necessary if the student has sustained any injury or had a significant illness since their physical was performed. **All doctor's notes should be turned in to your school's Health Office.**

4.___ All athletes must have had a **Tetanus shot** within the past 10 years **on record** with the school nurse. Consider asking your physician's office for a copy of your Immunization Record with your physical.

PLEASE NOTE:
You may be contacted if any of the information provided raises questions or concerns by the nurses during the processing of Sports Forms.
In addition, clearance for students with a history of multiple concussions may be delayed due to the need for District Physician approval.

Thank You!

ATHLETIC PROGRAM PERMISSION SLIP AND MEDICAL RECERTIFICATION

(PLEASE PRINT WHEN COMPLETING THIS FORM)
Valid **ONLY** if returned and signed within **30 days** before start of sports season.

OFFICE USE ONLY
Girls: ____ Boys: ____ Season: _____
School: _____ Tanner: _____
Selective Classification: _____
Coach's signature for transfer: _____

SPORT: _____ **LEVEL**: **Varsity / Junior Varsity / Freshman / Modified A / Modified B**
(Please Circle one)

SECTION I – *STUDENT INFORMATION*

Student: _____ **Grade:** _____ **Birthdate:** _____ **Age:** _____ **Sex:** _____

Parent/Guardian #1: _____

Home #_____ Work #_____ Cell #_____ Email_____

Parent/Guardian #2: _____

Home #_____ Work #_____ Cell #_____ Email_____

Student Address: _____
(Street) (Apt. #) (City) (Zip)

Emergency Contact Person (*OTHER than Mom or Dad*):

Name: _____ **Relationship:** _____ **Phone:** _____

Physician: _____ **Phone:** _____

Dentist: _____ **Phone:** _____

Preferred Hospital: _____ **Did you attend Penfield Central School last year?** _____

Insurance Carrier: _____ **Policy #:** _____

SECTION II – *PARENT PERMISSION & STUDENT AGREEMENT*

Our signatures below indicate:

- Permission to try out for and participate in interscholastic athletics
- Permission to ride bus to and from athletic contests
- Permission for Emergency Transportation and Treatment in the event of injury
- That we have read, understand, and agree to follow the Student Athletic Code of Conduct, Drug Policy and Academic Eligibility Policy
- That we have received an informational packet on concussions

I understand that participation in the Penfield Interscholastic Athletic Program involves rigorous physical activity and risks of physical injury including catastrophic injury and/or death, and we assume these risks. I further certify that the information I have provided is accurate, that the participant is in good physical condition, and has no medical or physical conditions that would restrict his/her participation in this activity.

All athletic events, including non-contact sports carry some risk of participants sustaining impact to their head which can result in a mild traumatic brain injury commonly referred to as a concussion. This can be a potentially serious condition with significant health implications, and any student athlete exhibiting its signs and symptoms will be removed from play and shall be evaluated by a physician, a nurse practitioner or a physician's assistant. Parents and legal guardians are encouraged to visit the district's website under Athletics and look for Concussion Management for further information.

_____ _____ _____
(Parent/Guardian Signature) **(Student Signature)** **(Date)**

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SECTION III – *STUDENT HEALTH HISTORY REVIEW*

(See Page 3 and answer all questions provided)

***The NYSPHSAA states that a student cannot participate in athletics without the approval of the school medical officer. Physicals are valid for 12 continuous months. A health history update (recertification) is required at the start of **EACH SEASON**. **If an injury has taken place; or if the student has a prolonged absence (5 consecutive days) due to an illness they must have a release from a physician**.

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FOR HEALTH OFFICE USE ONLY:

DATE OF PHYSICAL EXAM ON FILE: _____ **TETANUS DATE:** _____

SCHOOL NURSE SIGNATURE: _____ **DATE:** _____

SECTION III – STUDENT HEALTH HISTORY REVIEW **Date:**_____

Student's Name:_____ ☐ **Male** ☐ **Female** **Grade Level:**_____

	- TO BE COMPLETED BY PARENT OR GUARDIAN - ***Please answer questions below to indicate if your child has or has ever had the following:***	***Yes***	***No***	**Indicate Date of Occurrence**
1	Within the last year, has the athlete sustained any injury which required medical attention or had any illness which lasted longer than one week or required surgery?	☐ **Yes**	☐ **No**	
2	Has s/he had any contagious skin problems?	☐ **Yes**	☐ **No**	
3	Does s/he have an ongoing medical condition? Please check below: ☐Asthma ☐Diabetes ☐Seizures ☐Marfan's Syndrome ☐Kawasaki's Disease ☐Sickle Cell Trait or Disease ☐Other	☐ **Yes**	☐ **No**	
4	Is s/he currently taking any medications or pills (prescription, over-the-counter or recreational)?	☐ **Yes**	☐ **No**	
5	Has s/he ever had surgery?	☐ **Yes**	☐ **No**	
6	Has s/he ever spent the night in a hospital?	☐ **Yes**	☐ **No**	
7	Does s/he have a life threatening allergy? Please check below: ☐Medication ☐Food ☐Insect Bites ☐Pollen ☐Latex ☐Other	☐ **Yes**	☐ **No**	
8	Does s/he carry an Epi-pen (epinephrine)?	☐ **Yes**	☐ **No**	
9	Has s/he ever complained of light-headedness, dizziness or fainted during or after exercise?	☐ **Yes**	☐ **No**	
10	Has s/he ever complained of chest pain, tightness or pressure during or after exercise?	☐ **Yes**	☐ **No**	
11	Has s/he ever complained of fluttering in their chest, skipped beats, or their heart racing, or does s/he have a pacemaker?	☐ **Yes**	☐ **No**	
12	Has a medical professional ever denied or restricted his/her participation in sports for any heart-related reasons?	☐ **Yes**	☐ **No**	
13	Has s/he been told s/he has a heart condition or problem?	☐ **Yes**	☐ **No**	
14	Has s/he ever had high or low blood pressure?	☐ **Yes**	☐ **No**	
15	Does s/he wheeze or cough frequently during or after exercise?	☐ **Yes**	☐ **No**	
16	Has a health care provider ever said s/he has asthma?	☐ **Yes**	☐ **No**	
17	Does s/he use or carry an inhaler or nebulizer?	☐ **Yes**	☐ **No**	
18	Has s/he ever become ill while exercising in hot weather?	☐ **Yes**	☐ **No**	
19	Has there been an unexplained weight loss or weight gain during the past six months?	☐ **Yes**	☐ **No**	
20	Does s/he lose weight for his/her sport?	☐ **Yes**	☐ **No**	
21	Does s/he have a history of eating disorders or ever tried to control weight by vomiting, using laxatives, diuretics, diet pills or by exercising excessively?	☐ **Yes**	☐ **No**	
22	Does s/he have abdominal problems or hernia?	☐ **Yes**	☐ **No**	
23	Has s/he ever had a hit to the head that caused a headache, dizziness, nausea, or confusion, or been told s/he had a concussion?	☐ **Yes**	☐ **No**	
24	Does s/he ever have headaches with exercise?	☐ **Yes**	☐ **No**	
25	Has s/he ever had a seizure or been diagnosed with a seizure disorder?	☐ **Yes**	☐ **No**	
26	Has s/he ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling?	☐ **Yes**	☐ **No**	
27	Does s/he use a brace, orthotic, retainer, or other protective device?	☐ **Yes**	☐ **No**	
28	Does s/he have any problems with his/her hearing or wear hearing aides?	☐ **Yes**	☐ **No**	
29	Does s/he have vision in one eye only?	☐ **Yes**	☐ **No**	
30	Does s/he have any vision problems requiring the use of glasses, contacts, or protective eyeware?	☐ **Yes**	☐ **No**	
31	Does s/he have only one functioning kidney?	☐ **Yes**	☐ **No**	
32	Does s/he have a bleeding disorder?	☐ **Yes**	☐ **No**	
	FEMALES ONLY:			
33	Has there been a recent change in her menstrual patterns?	☐ **Yes**	☐ **No**	
34	When was her most recent menstrual period? _____/_____/_____			
	MALES ONLY:			
35	Does he have only one testicle?	☐ **Yes**	☐ **No**	
	FAMILY HISTORY:			
36	Has an immediate family member died suddenly before the age of 50 from an unknown or heart-related cause? (do not include accidents)	☐ **Yes**	☐ **No**	

***If *'Yes'* to any of the above, explain fully below. Failure to provide complete answers may delay processing of paperwork.**

#_____

#_____

#_____

#_____

#_____