# *Fall 2020 Sports Form*

## Charles Finney High School


- **Julie Pancio, RN**
- **387-3770 x230**
- **Fax: 641-0431**


***** 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)**

**********
*

## 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**.

**********
*

**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:<br>☐Asthma ☐Diabetes ☐Seizures ☐Marfan's Syndrome ☐Kawasaki's Disease<br>☐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:<br>☐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.**

**#**_____

**#**_____

**#**_____

**#**_____

**#**_____