SPORTS FORM

CHECKLIST FOR STUDENT-ATHLETES

1._____ Student-Athletes must have a valid **Physical Examination** on file in the Health Office. New York State regulations specify that physical exams are only valid for a period of one year. To be eligible to participate, physical exams must be dated within one year of the day your sport begins.

2._____ We ask that all **Sports Forms** be submitted directly to the 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. (This can also be turned into the Nurse).

3._____ All athletes must have had a **Tetanus shot** within the past 10 years on record with the school nurse. Please fill in the date in the Student Information section.

Please Note:

- A new permission slip is needed before EACH sports season.
- Any out of pocket expenses due to an injury in football will not be reimbursed.
- 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,** and then turned in to the school nurse.
- Forms dated or handed in prior to that time will be invalid and not accepted.
- **DEADLINE:** All forms are due in the Nurse's Office at least one week prior to the first practice or try-out date.
- You may be contacted if any of the information provided raises questions or concerns by the nurse during the processing of the Sports Form. In addition, clearance for students with a history of multiple concussions or cardiac complications from Covid-19 may be delayed due to the need for Physician approval.
- The NYSPHSAA states that a student cannot participate in athletics without the approval of the school medical officer. 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.

Thank You!

Dayna Fantigrossi BSN, RN
dfantigrossi@finneyschool.org
Fax: 585.641.0431 Phone: 585.387.3770 (EXT 230)

FOR HEALTH OFFICE USE ONLY:

Office Use Only: Girls:_____ Boys: _____ Season: Fall Winter Spring Cleared:_____

Date of Physical Exam on File: _____ Tetanus Date_____

School Nurse Signature: _____ Date_____

ATHLETIC PROGRAM PERMISSION SLIP AND MEDICAL RECERTIFICATION

SPORT:_____ **LEVEL: Varsity/Junior Varsity//Modified**

(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 _____

Emergency Contact Person

Name: _____ Relationship: _____ Phone: _____

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Preferred Hospital: _____

Insurance Carrier: _____ Policy #: _____

Tetanus Date_____Date of Last Physical_____

SECTION II - *PARENT PERMISSION & STUDENT AGREEMENT*

The signatures below indicate

- Permission to try out for and participate in interscholastic athletics
- Permission to ride the bus/van to and from athletic contests
- Permission for emergency transportation and treatment in the event of an injury
- That you have read, understand, and agree to follow the Academic Eligibility Policy
- That you understand the risk of concussion or injury

I understand that participation in the Finney 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 healthcare provider.

_____ _____ _____

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

SECTION III - *STUDENT HEALTH HISTORY REVIEW*

	- 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***	***Explanation***
1	Within the last year, has the athlete sustained any injury which required medical attention or had any illness which required surgery or caused them to miss practice or a game? If yes, please describe.	**Yes**	**No**	
2	Has s/he had any contagious skin problems?	**Yes**	**No**	
3	Does s/he have an ongoing medical condition? Please circle: Asthma, diabetes, seizures, Marfan's Syndrome, 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 or spent the night in the hospital?	**Yes**	**No**	
6	Has s/he been diagnosed with mononucleosis within the last month?	**Yes**	**No**	
7	Does s/he have a life threatening allergy? Please circle: Medication, food, insect bite, pollen, latex, other:	**Yes**	**No**	
8	Does s/he carry an Epi-pen (epinephrine)? Have they ever had anaphylaxis?	**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 or been told by a health care provider that they have fluttering in their chest, skipped beats, or a racing heart? Have they ever had (please circle): EKG, echocardiogram, stress test?	**Yes**	**No**	
12	Has a medical professional ever denied or restricted his/her participation in sports for any reasons?	**Yes**	**No**	
13	Has s/he been told that s/he has a heart condition or problem or any of the following? Please circle: High or low blood pressure, high cholesterol, implanted cardiac defibrillator (ICD), pacemaker, heart infection, heart murmur, or Kawasaki Disease.	**Yes**	**No**	
14	Does s/he have a bleeding disorder?	**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 or exercise-induced asthma?	**Yes**	**No**	
17	Does s/he use or carry an inhaler or nebulizer?	**Yes**	**No**	
18	Has s/he ever complained of getting extremely tired or short of breath during exercise?	**Yes**	**No**	
19	Does s/he have a special diet or need to avoid certain foods?	**Yes**	**No**	
20	Are there any concerns about your child's weight?	**Yes**	**No**	
21	Has s/he had an eating disorder, lost weight for a sport or had unexplained weight loss/gain?	**Yes**	**No**	
22	Does s/he have stomach/GI problems or any bulge that would suggest a 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 or experience migraines at any time?	**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 aids/cochlear implant?	**Yes**	**No**	
29	Does s/he have problems with vision or only have vision in one eye or wear protective eyewear such as goggles/face shield?	**Yes**	**No**	
30	Does s/he have any devices or prostheses? Please circle: Insulin pump or sensor, ostomy bag, etc	**Yes**	**No**	
31	Does s/he have only one functioning kidney?	**Yes**	**No**	
32	Has your child tested positive for COVID-19? If No, skip to 36. If Yes, date of positive test:	**Yes**	**No**	
33	If they tested positive for COVID-19, was your child symptomatic?	**Yes**	**No**	
34	Did your child see a health care provider for their COVID-19 symptoms?	**Yes**	**No**	
35	Was your child hospitalized for COVID-19 or diagnosed with Multisystem Inflammatory Syndrome (MISC)?	**Yes**	**No**	
	FEMALES ONLY:			
36	Does she have regular periods?	**Yes**	**No**	
	MALES ONLY:			
37	Does he have only one testicle?	**Yes**	**No**	
	FAMILY HISTORY:			
38	Has a relative had any of the following: Please circle: Enlarged heart, arrhythmogenic right ventricular cardiomyopathy, heart rhythm problem such as long or short QT interval, Brugada Syndrome, catecholaminergic ventricular tachycardia, Marfan Syndrome (aortic rupture), heart attack at age 50 or younger, pacemaker or implanted cardiac defibrillator (ICD), known heart abnormalities, structural heart abnormality, sudden death before age 50, unexplained fainting, seizures, drowning, near drowning or car accident before age 50?	**Yes**	**No**	