The Charles Finney School

SPORTS FORM

CHECKLIST FOR STUDENT-ATHLETES

1._____ Student-Athletes must have a valid **Physical Examination** on file in the Health Office at school. 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 month your sport begins. If you are unsure of when your physical expires, check with your school nurse as soon as possible.

2._____ We ask that all **Athletic Program Permission Slip/Medical Recertification 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 should turn in the **Covid-19 Information Form**. This details the student's history with Covid-19 and how it affected them. If the student has had Covid-19 they must be cleared by a doctor for Return to Play. See the Nurse if you have questions about this.

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:

- 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,** 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 may be delayed due to the need for Physician approval.

Thank You!

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

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 #: _____

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 Student Athletic Code of Conduct, Drug Policy, and 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 physician, a nurse practitioner or a physician's assistant. Parents and legal guardians are encouraged to visit the school website unde Athletics and look for Concussion Management under the 'Forms' section for further information.

_____ _____ _____

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

FOR HEALTH OFFICE USE ONLY:

Date of Physical Exam on File: _____ Tetanus Date_____

School Nurse Signature: _____ Date_____

SECTION III - *STUDENT HEALTH HISTORY REVIEW*

***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.

	- 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 Occurence***
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 circle 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 circle 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 aids?	**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 eyewear?	**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.**

_____

_____

_____

COVID-19 INFORMATION FOR STUDENTS PARTICIPATING IN SPORTS

Please Circle Yes or No

1. Has your child ever tested positive for COVID-19? **YES NO**
2. Was your child symptomatic? **YES NO**
3. Did your child see a healthcare provider (HCP) for their COVID-19 symptoms? **YES NO**
4. Did your child have any cardiac symptoms (new fast or slow heart rate, chest tightness or pain, blood pressure changes, or HCP diagnosed cardiac condition)? If yes, please provide additional information. **YES NO**
5. Was your child hospitalized? If yes, provide date(s)? If yes, was your child diagnosed with Multisystem Inflammatory Syndrome (MISC)? If yes, is your child under a HCP's care for this? **YES NO**

Please explain fully any questions you answered yes to in the space below and include dates if known.

_____

_____

_____

_____ _____

(Parent/Guardian Signature) (Date)

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