Winter 2019-2020 Sports Form

The Charles Finney 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 Winter 2019-2020 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

OFFICE USE ONLY
Girls: ____ Boys: ____ Season: _______
School: __________ Tanner: _________
Selective Classification: _____________
Coach's signature for transfer: ________

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

SPORT:______________________________ **LEVEL**: **Varsity / Junior Varsity / Modified**
(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 The Charles Finney 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 Charles Finney School 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.**

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