## PARENT PERMISSION FOR INTERSCHOLASTIC PARTICIPATION

Student's Name_____Sport_____ V JV MS (circle one)
*Print Last Name First*

Address_____Age_____ Grade_____ Male Female (circle one)

Date of Birth_____ Year you began or will begin 9th Grade_____

Parents' Name_____Home Phone #_____Cell #_____

Physician's Name & Tel. #_____

Emergency Contact Person & Tel. #_____

Known Allergies_____

Important Information for Parents

**What are concussions?**

*Concussions are brain injuries caused by external forces to the head, neck or face. Further complications from concussions or their management can lead to intracranial hematomas (bleeding in the brain), balance and coordination problems, or Second Impact Syndrome.*

**How do concussions occur?**

*A bump, blow, or jolt to the head can cause a concussion, a type of traumatic brain injury (TBI). Concussions can also occur from a blow to the body that causes the head and brain to move rapidly back and forth. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious. During sports and recreation activities, concussions may result from a fall or from players colliding with each other, the ground, or with obstacles, such as a goalpost.*

**Signs and symptoms**

*Most concussions present with a headache and dizziness. These are the most common early signs of a concussion. Other signs and symptoms may include blurred vision, double vision, memory loss, loss of consciousness, nausea. It should be noted that ANY of these symptoms lasting longer than 15 minutes after a blow to the head, may indicate a concussion has occurred.*

**When can a student return to activities after a concussion?**

*Absolutely no student may return to activities the same day of a concussion. There is no exact timeline for a concussion return to activities. All concussions present differently. All students must be symptom free before returning to activity. At Plainedge, a student may return only after they have medical clearance from the **Chief Medical officer for the Plainedge School District.***

**Note: Prior to clearance for Plainedge School District activities such as interscholastic athletics and/or at any point during the year, it is the responsibility of the Parents and the student to alert the Plainedge School District of any prior or new concussions.**

I hereby give my son/daughter _____ permission to engage in interscholastic athletics as a member of the _____ team for the current school year. I further understand that participation in athletics could lead to serious or, in certain cases, fatal injury.

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Date_____ Parent's Signature_____

Date_____ Student's Signature_____

This card indicates:

1. The updated Health History Form is on file with the nurse
2. The sports physical has been completed and the above named student is approved for athletic participation

Nurse's Signature_____ Date_____

NYSED Interval Health History for Athletics–Two Page Form
Both pages must be completed.

| | |
|---|---|
| Student Name: | DOB: |
| School Name: | Age: |
| Grade (check): ☐7 ☐8 ☐9 ☐10 ☐11 ☐12 | Level (check): ☐ Modified ☐ Fresh ☐ JV ☐ Varsity |
| Sport: | Limitations: ☐ Yes ☐ No |
| Date of last health exam: | Date form completed: |

**Health History to Be Completed by Parent/Guardian, Provide Details to Any Yes Answers on Back.**
Medicines needed at practice and/or athletic event require the proper paperwork, contact school with questions.

**Has/Does your child:**

| General Health Concerns | No | Yes |
|---|---|---|
| 1. Ever been restricted by a health care provider from sports participation for any reason? | ☐ | ☐ |
| 2. Have an ongoing medical condition? ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Sickle Cell trait or disease ☐ Other | | |
| 3. Ever had surgery? | ☐ | ☐ |
| 4. Ever spent the night in a hospital? | ☐ | ☐ |
| 5. Been diagnosed with Mononucleosis within the last month? | ☐ | ☐ |
| 6. Have only one functioning kidney? | ☐ | ☐ |
| 7. Have a bleeding disorder? | ☐ | ☐ |
| 8. Have any problems with his/her hearing or wears hearing aid(s)? | ☐ | ☐ |
| 9. Have any problems with his/her vision or has vision in only one eye? | ☐ | ☐ |
| 10. Wear glasses or contacts? | ☐ | ☐ |
| **Allergies** | | |
| 11. Have a life-threatening allergy? Check any that apply: ☐ Food ☐ Insect Bite ☐ Latex ☐ Medicine ☐ Pollen ☐ Other | | |
| 12. Carry an epinephrine auto-injector? | | |
| **Breathing (Respiratory) Health** | **No** | **Yes** |
| 13. Ever complained of getting more tired or short of breath than his/her friends during exercise? | ☐ | ☐ |
| 14. Wheeze or cough frequently during or after exercise? | ☐ | ☐ |
| 15. Ever been told by a health care provider they have asthma? | ☐ | ☐ |
| 16. Use or carry an inhaler or nebulizer? | ☐ | ☐ |

**Has/Does your child:**

| Concussion/ Head Injury History | No | Yes |
|---|---|---|
| 17. Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told he/she had a concussion? | ☐ | ☐ |
| 18. Ever had a head injury or concussion? | ☐ | ☐ |
| 19. Ever had headaches with exercise? | ☐ | ☐ |
| 20. Ever had any unexplained seizures? | ☐ | ☐ |
| 21. Currently receive treatment for a seizure disorder or epilepsy? | ☐ | ☐ |
| **Devices/Accommodations** | **No** | **Yes** |
| 22. Use a brace, orthotic, or other device? | ☐ | ☐ |
| 23. Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)? If yes, there may be need for another required form to be filled out. | ☐ | ☐ |
| 24. Wear protective eyewear, such as goggles or a face shield? | ☐ | ☐ |
| **Family History** | **No** | **Yes** |
| 25. Have any relative who's been diagnosed with a heart condition, such as a murmur, developed hypertrophic cardiomyopathy, Marfan Syndrome, Brugada Syndrome, right ventricular cardiomyopathy, long QT or short QT syndrome, or catecholaminergic polymorphic ventricular tachycardia? | ☐ | ☐ |
| **Females Only** | **No** | **Yes** |
| 26. Begun having her period? | ☐ | ☐ |
| 27. Age periods began: | | |
| 28. Have regular periods? | ☐ | ☐ |
| 29. Date of last menstrual period: | | |
| **Males Only** | **No** | **Yes** |
| 30. Have only one testicle? | ☐ | ☐ |
| 31. Have groin pain or a bulge or hernia in the groin? | ☐ | ☐ |

## NYSED Interval Health History for Athletics – Page 2

Student Name:

School Name: DOB:

| Has/Does your child: | | |
|---|---|---|
| **Heart Health** | **No** | **Yes** |
| 32. Ever passed out during or after exercise? | ☐ | ☐ |
| 33. Ever complained of light headedness or dizziness during or after exercise? | ☐ | ☐ |
| 34. Ever complained of chest pain, tightness or pressure during or after exercise? | ☐ | ☐ |
| 35. Ever complained of fluttering in their chest, skipped beats, or their heart racing, or does he/she have a pacemaker? | ☐ | ☐ |
| 36. Ever had a test by a health care provider for his/her heart (e.g. EKG, echocardiogram stress test)? | ☐ | ☐ |
| 37. Ever been told they have a heart condition or problem by a health care provider? If so, check all that apply: ☐Heart infection ☐Heart Murmur ☐High Blood Pressure ☐Low Blood Pressure ☐High Cholesterol ☐Kawasaki Disease ☐Other: | | |
| **Injury History** | **No** | **Yes** |
| 38. Ever been diagnosed with a stress fracture? | ☐ | ☐ |

| Has/Does your child: | | |
|---|---|---|
| **Injury History continued** | **No** | **Yes** |
| 39. Ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling? | ☐ | ☐ |
| 40. Ever had an injury, pain, or swelling of joint that caused him/her to miss practice or a game? | ☐ | ☐ |
| 41. Have a bone, muscle, or joint injury that bothers him/her? | ☐ | ☐ |
| 42. Have joints become painful, swollen, warm, or red with use? | ☐ | ☐ |
| **Skin Health** | **No** | **Yes** |
| 43. Currently have any rashes, pressure sores, or other skin problems? | ☐ | ☐ |
| 44. Have had a herpes or MRSA skin infections? | ☐ | ☐ |
| **Stomach Health** | **No** | **Yes** |
| 45. Ever become ill while exercising in hot weather? | ☐ | ☐ |
| 46. Have a special diet or need to avoid certain foods? | ☐ | ☐ |
| 47. Have to worry about his/her weight | ☐ | ☐ |
| 48. Have stomach problems? | ☐ | ☐ |
| 49. Ever had an eating disorder? | ☐ | ☐ |

| **COVID-19 Information** | **No** | **Yes** |
|---|---|---|
| 50. Has your child ever tested positive for COVID-19? | ☐ | ☐ |
| 51. Was your child symptomatic? | ☐ | ☐ |
| 52. Did your child see a healthcare provider (HCP) for their COVID-19 symptoms? | ☐ | ☐ |
| 53. 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. | ☐ | ☐ |
| 54. 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? | ☐ | ☐ |

**Please explain fully any question you answered yes to in the space below, include dates if known.** Use additional pages if necessary.

Parent/Guardian Signature: _____ Date: _____

# REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

## TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

**Note:** NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

### STUDENT INFORMATION

| | | |
|---|---|---|
| Name: | Sex: ☐ M ☐ F | DOB: |
| School: | Grade: | Exam Date: |

### HEALTH HISTORY

| | |
|---|---|
| **Allergies** ☐ No | ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached |
| ☐ Yes, indicate type | ☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental |
| **Asthma** ☐ No | ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached |
| ☐ Yes, indicate type | ☐ Intermittent ☐ Persistent ☐ Other: _____ |
| **Seizures** ☐ No | ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached |
| ☐ Yes, indicate type | ☐ Type: _____ Date of last seizure: _____ |
| **Diabetes** ☐ No | ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached |
| ☐ Yes, indicate type | ☐ Type 1 ☐ Type 2 ☐ HbA1c results: _____ Date Drawn: _____ |

**Risk Factors for Diabetes or Pre-Diabetes:**

*Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother; and/or pre-diabetes.*

BMI_____kg/m2 **Percentile (Weight Status Category):** ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and>

**Hyperlipidemia:** ☐ No ☐ Yes **Hypertension:** ☐ No ☐ Yes

### PHYSICAL EXAMINATION/ASSESSMENT

**Height:** **Weight:** **BP:** **Pulse:** **Respirations:**

| TESTS | Positive | Negative | Date |
|---|---|---|---|
| PPD/ PRN | ☐ | ☐ | |
| Sickle Cell Screen/PRN | ☐ | ☐ | |
| **Lead Level Required Grades Pre- K & K** | | | **Date** |
| ☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL | | | |

**Other Pertinent Medical Concerns**

One Functioning: ☐ Eye ☐ Kidney ☐ Testicle

☐ Concussion – Last Occurrence: _____

☐ Mental Health: _____

☐ Other:

☐ **System Review and Exam Entirely Normal**

**Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities**

| | | | | |
|---|---|---|---|---|
| ☐ HEENT | ☐ Lymph nodes | ☐ Abdomen | ☐ Extremities | ☐ Speech |
| ☐ Dental | ☐ Cardiovascular | ☐ Back/Spine | ☐ Skin | ☐ Social Emotional |
| ☐ Neck | ☐ Lungs | ☐ Genitourinary | ☐ Neurological | ☐ Musculoskeletal |

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

| Diagnoses/Problems (list) | ICD-10 Code |
|---|---|
| | |
| | |
| | |
| | |

| Name: | | | | DOB: |
|---|---|---|---|---|
| **SCREENINGS** | | | | |
| **Vision** | **Right** | **Left** | **Referral** | **Notes** |
| Distance Acuity | 20/ | 20/ | ☐ Yes ☐ No | |
| Distance Acuity With Lenses | 20/ | 20/ | | |
| Vision – Near Vision | 20/ | 20/ | | |
| Vision – Color ☐ Pass ☐ Fail | | | | |
| **Hearing** | **Right dB** | **Left dB** | **Referral** | |
| Pure Tone Screening | | | ☐ Yes ☐ No | |
| **Scoliosis** Required for boys grade 9 | **Negative** | **Positive** | **Referral** | |
| And girls grades 5 & 7 | ☐ | ☐ | ☐ Yes ☐ No | |
| Deviation Degree: | | Trunk Rotation Angle: | | |
| **Recommendations:** | | | | |

**RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK**

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications

☐ **No Contact Sports** **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling

☐ **No Non-Contact Sports** **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field

☐ **Other Restrictions:**

☐ **Developmental Stage for Athletic Placement Process ONLY**

Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports

Student is at **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Accommodations:** Use additional space below to explain

☐ Brace*/Orthotic ☐ Colostomy Appliance* ☐ Hearing Aids

☐ Insulin Pump/Insulin Sensor* ☐ Medical/Prosthetic Device* ☐ Pacemaker/Defibrillator*

☐ Protective Equipment ☐ Sport Safety Goggles ☐ Other:

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: _____

**MEDICATIONS**

☐ **Order Form for Medication(s) Needed at School attached**

| **List medications taken at home:** | | |
|---|---|---|
| | | |

**IMMUNIZATIONS**

☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No

**HEALTH CARE PROVIDER**

| Medical Provider Signature: | **Date:** |
|---|---|
| Provider Name: *(please print)* | Stamp: |
| Provider Address: | |
| Phone: | |
| Fax: | |

**Please Return This Form To Your Child's School When Entirely Completed.**