PLAINEDGE PUBLIC SCHOOLS
HEALTH HISTORY FOR INTERSCHOLASTIC ATHLETICS

Student Name ____________________________ Grade ____________

Dear Parent or Guardian:

Your son/daughter has elected to participate in interscholastic athletics. To be sure your son/daughter has your permission, and in order to make a proper medical evaluation of your child, you must do the following:
FILL OUT THIS FORM COMPLETELY AND RETURN TO THE SCHOOL NURSE NO MORE THAN 30 DAYS PRIOR TO THE START OF THE SPORT SEASON. Thank you for your cooperation.

Please circle the appropriate answer:
1. Any feeling of faintness, dizziness or fatigue after heavy exertion? Yes No
2. Any fractures, dislocations, severe sprains or chronic diseases? Yes No
3. Has student ever been hospitalized? Yes No
4. Has student ever had surgery? Yes No
5. Does student have any allergies? Yes No
6. Does student take any medication now? Yes No
7. Has student ever been refused permission to participate in athletics? Yes No
8. Does student wear glasses? Contact lenses? Yes No

Please explain any Yes answers to the questions above. (Use back of form if needed.)

Please check if the student has ever had any of the following:

___ Anemia ___ High Blood Pressure ___ Jaundice
___ Asthma ___ Heart Disease ___ Kidney Disease
___ Diabetes ___ Heart Murmur ___ Seizures
___ Prolonged Bleeding ___ Chronic Cough ___ Tuberculosis
___ Rheumatic Fever ___ Hearing Loss ___ *Concussion

*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 Parent and the student to alert the Plainedge School District of any prior or new concussions.

Please give date and explanation if you check any of the above. (Use back of form if needed.)

By signing below, the student and parent/guardian acknowledges that they have provided up to date medical information.

_________ Student Signature ____________ Parent or Guardian Signature ____________ Date ____________

Date __________________ Nurse's Copy
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.

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 ___________________________
# 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

<table>
<thead>
<tr>
<th>Name:</th>
<th>Sex: □ M □ F</th>
<th>DOB:</th>
</tr>
</thead>
<tbody>
<tr>
<td>School:</td>
<td>Grade:</td>
<td>Exam Date:</td>
</tr>
</tbody>
</table>

## HEALTH HISTORY

### Allergies

- □ No
- □ Yes, indicate type: □ Food □ Insects □ Latex □ Medication □ Environmental □ Anaphylaxis Care Plan Attached

### Asthma

- □ No
- □ Yes, indicate type: □ Intermittent □ Persistent □ Other: ______________________ □ Asthma Care Plan Attached

### Seizures

- □ No
- □ Yes, indicate type: □ Type: ______________________ □ Seizure Care Plan Attached
  - Date of last seizure: ____________

### Diabetes

- □ No
- □ Yes, indicate type: □ Type 1 □ Type 2 □ HbA1c results: ____________ □ Diabetes Medical Mgmt. Plan Attached
  - 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.

<table>
<thead>
<tr>
<th>BMI</th>
<th>Percentile (Weight Status Category):</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>□ &lt;5th □ 5th-49th □ 50th-84th □ 85th-94th □ 95th-98th □ 99th and&gt;</td>
</tr>
</tbody>
</table>

## HYPERLIPIDEMIA

- □ No □ Yes

## HYPTERTENSION

- □ No □ Yes

## PHYSICAL EXAMINATION/ASSESSMENT

### Height:

- Weight:

### BP:

- Pulse:

### RESPIRATIONS:

- Other Pertinent Medical Concerns:

<table>
<thead>
<tr>
<th>TESTS</th>
<th>Positive</th>
<th>Negative</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPD/PRN</td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Sickle Cell Screen/PRN</td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
</tbody>
</table>

### Lead Level Required Grades Pre-K & K

- Date: ______________________

<table>
<thead>
<tr>
<th>Test Done</th>
<th>Lead Elevated &gt; 10 μg/dL</th>
</tr>
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<tbody>
<tr>
<td>□</td>
<td>□</td>
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</table>

**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:**

<table>
<thead>
<tr>
<th>Diagnoses/Problems (list)</th>
<th>ICD-10 Code</th>
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**Additional Information Attached**
Name: 

<table>
<thead>
<tr>
<th>SCREENINGS</th>
<th>DOB:</th>
</tr>
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<tbody>
<tr>
<td>Vision</td>
<td>Right</td>
</tr>
<tr>
<td>Distance Acuity</td>
<td>20/</td>
</tr>
<tr>
<td>Distance Acuity With Lenses</td>
<td>20/</td>
</tr>
<tr>
<td>Vision – Near Vision</td>
<td>20/</td>
</tr>
<tr>
<td>Vision – Color</td>
<td>☐ Pass ☐ Fail</td>
</tr>
<tr>
<td>Hearing</td>
<td>Right dB</td>
</tr>
<tr>
<td>Pure Tone Screening</td>
<td></td>
</tr>
<tr>
<td>Scoliosis</td>
<td>Required for boys grade 9</td>
</tr>
<tr>
<td>And girls grades 5 &amp; 7</td>
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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
  ☐ No Contact Sports
  ☐ No Non-Contact Sports
  □ 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 NYSIS Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature: 

Provider Name: (please print)

Provider Address:

Phone: 

Fax: 

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

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