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 <u>NO MORE THAN 30 DAYS PRIOR</u> 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 <u>Yes</u> 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

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

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type — ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached ☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No ☐ Yes, indicate type — ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached ☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No ☐ Yes, indicate type — ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached ☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No ☐ Yes, indicate type — ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached ☐ 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.