

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 _____

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

Student Name:		DOB:
School Name:		Age:
Grade (check): <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12	Level (check): <input type="checkbox"/> Modified <input type="checkbox"/> Fresh <input type="checkbox"/> JV <input type="checkbox"/> Varsity	
Sport:	Limitations: <input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have an ongoing medical condition? <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Seizures <input type="checkbox"/> Sickle Cell trait or disease <input type="checkbox"/> Other		
3. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>
5. Been diagnosed with Mononucleosis within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have only one functioning kidney?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have a bleeding disorder?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have any problems with his/her hearing or wears hearing aid(s)?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have any problems with his/her vision or has vision in only one eye?	<input type="checkbox"/>	<input type="checkbox"/>
10. Wear glasses or contacts?	<input type="checkbox"/>	<input type="checkbox"/>

Allergies		
11. Have a life-threatening allergy? Check any that apply: <input type="checkbox"/> Food <input type="checkbox"/> Insect Bite <input type="checkbox"/> Latex <input type="checkbox"/> Medicine <input type="checkbox"/> Pollen <input type="checkbox"/> Other		
12. Carry an epinephrine auto-injector?	<input type="checkbox"/>	<input type="checkbox"/>

Breathing (Respiratory) Health	No	Yes
13. Ever complained of getting more tired or short of breath than his/her friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
14. Wheeze or cough frequently during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
15. Ever been told by a health care provider they have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
16. Use or carry an inhaler or nebulizer?	<input type="checkbox"/>	<input type="checkbox"/>

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?	<input type="checkbox"/>	<input type="checkbox"/>
18. Ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
19. Ever had headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
20. Ever had any unexplained seizures?	<input type="checkbox"/>	<input type="checkbox"/>
21. Currently receive treatment for a seizure disorder or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>
Devices/Accommodations	No	Yes
22. Use a brace, orthotic, or other device?	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>
24. Wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>

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?	<input type="checkbox"/>	<input type="checkbox"/>

Females Only	No	Yes
26. Begun having her period?	<input type="checkbox"/>	<input type="checkbox"/>
27. Age periods began:		
28. Have regular periods?	<input type="checkbox"/>	<input type="checkbox"/>
29. Date of last menstrual period:		
Males Only	No	Yes
30. Have only one testicle?	<input type="checkbox"/>	<input type="checkbox"/>
31. Have groin pain or a bulge or hernia in the groin?	<input type="checkbox"/>	<input type="checkbox"/>

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

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?	<input type="checkbox"/>	<input type="checkbox"/>
40. Ever had an injury, pain, or swelling of joint that caused him/her to miss practice or a game?	<input type="checkbox"/>	<input type="checkbox"/>
41. Have a bone, muscle, or joint injury that bothers him/her?	<input type="checkbox"/>	<input type="checkbox"/>
42. Have joints become painful, swollen, warm, or red with use?	<input type="checkbox"/>	<input type="checkbox"/>
Skin Health	No	Yes
43. Currently have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
44. Have had a herpes or MRSA skin infections?	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Health	No	Yes
45. Ever become ill while exercising in hot weather?	<input type="checkbox"/>	<input type="checkbox"/>
46. Have a special diet or need to avoid certain foods?	<input type="checkbox"/>	<input type="checkbox"/>
47. Have to worry about his/her weight?	<input type="checkbox"/>	<input type="checkbox"/>
48. Have stomach problems?	<input type="checkbox"/>	<input type="checkbox"/>
49. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>

COVID-19 Information	No	Yes
50. Has your child ever tested positive for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
51. Was your child symptomatic?	<input type="checkbox"/>	<input type="checkbox"/>
52. Did your child see a healthcare provider (HCP) for their COVID-19 symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>
54. Was your child hospitalized? If yes, provide date(s)	<input type="checkbox"/>	<input type="checkbox"/>
If yes, was your child diagnosed with Multisystem Inflammatory syndrome (MISC)?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, is your child under a HCP's care for this?	<input type="checkbox"/>	<input type="checkbox"/>

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: _____