

**Schalmont High School
Nurse's Office
Sandy VanEtten, R.N.
1 Sabre Drive
Schenectady, NY 12306
(518) 355-6110 x3041, Fax (518) 355-7025**

**FALL SPORTS CLEARANCE DATES
*Mandatory For Sports Participation***

To be held in the High School Nurse's Office for High School students ONLY.

What you must do to participate in Fall Sports:

- Come in person to the High School Nurse on one of the following dates and times.
July 18, 19, 25, 26 8:30am – 1:00pm
August 1, 2, 8, 9, 15 8:30am – 1:00pm
- **OR** mail or fax a completed Interval Health History form (must be signed and dated no more than 30 days from the start date of the sport) and/or Physical Form prior to July 26 to insure it will be processed in a timely fashion.

FAX to: (518) 355-7025
Faxing will be available
From July 19-26 **only**.

Mail to: Schalmont High School
c/o Sandy VanEtten, R. N.
1 Sabre Drive
Schenectady, NY 12306

- The nurse will check each student's health file for the latest physical. A Physical form shall be acceptable if it is administered not more than twelve months prior to the start date of the sport. ***The Physical form should indicate your son/daughter may participate in sports***
- All students approved by the nurse will have a sports participation card filed with a copy given to the coach by the nurse.

*****Practice or play is not allowed if any part of this
procedure is not completed*****

TO: Students and Parents
FROM: High School and Middle School Nurses
RE: Participation in Sports Program

Interval Health History Form:

Parents must complete this form. Parents must sign this form **no earlier than thirty days** prior to the first day of practice. This form must be completed prior to **each sport season**. Interval health history forms do not have to be completed if a physician physical was performed on the student thirty days prior to the first day of practice. This form must be handed into the nurse on sports clearance day **only**.

Physician Physicals:

The school physicians give physicals during the month of August each year at the High School Health office. The physicals can be used as sports physicals, 7th & 10th grade physicals, new student entrance physical and for the issue of working papers. Please see the sports information dates for the August physicals. Dates can be obtained from the nurse, athletic director's office, main office, guidance office and the internet: www.schalmont.org (go to HS Sports). Your own family doctor can also give physicals. A copy of the physical needs to be completed and sent to the schools nurse to be reviewed and placed in your child's health file. **Your doctor will not send this without your request.** Physicals are valid through the last day of the month in which the examination was conducted rather than 365 days from the last examination. If the 12 month period for the physical exam expires at the start or during a sport season, participants may conclude that until the next sport season – **as long as an Interval health history was completed prior to the sport season.**

Sports Clearance:

Students are required to attend the sports informational meeting with their coach. The sports dates and information packet will be handed out to each athlete. Students will be required to show up at the health office with their coaches on a specific date/time. The nurse will review the latest physical date or the interval health form. If the student is approved, a sports participation form will be issued to that student to give to the coach on the first day of practice.

Permission Forms:

To be completed with all emergency names and numbers, handed into the coaches who will keep the forms on them to refer to in case of an accident.

Injuries:

All injuries should be reported to the coach and athletic trainer. An accident report will be completed by the coach who will submit it to the school nurse. The nurse will send insurance forms to those requiring them. All questions concerning insurance matters should be directed to Joseph C. Lenz in the District Office.

****Reminder****

Coaches cannot approve or accept physician physical forms. They must be given directly to the nurse. These are legal documents, which are kept on file.

— **When a physician has written an excuse for a student not to participate in a sport/gym due to physical injury, the school legally must abide by the physicians order. A parent/s written or verbal request disregarding the physician order will not be honored.**

Schalmont Central School District Interval Health History Form for Sports Participation

Prior to the start of tryout sessions or practice at the beginning of each season, a health history review for each student **must** be completed.

Part A TO BE COMPLETED BY THE STUDENT

Student Name _____ DOB _____
 Grade _____ Age _____ Grade level (check one) ___ Var ___ JV ___ Frosh ___ Jr. High
 Sport _____

Part B TO BE COMPLETED BY THE PARENT OR GUARDIAN

NOTE: "Yes" to any of these questions does not mean automatic disqualification from participation in sports. However, it will require a review and approval by the school physician before the student can report to practice or tryouts.

HISTORY SINCE LAST HEALTH APPRAISAL

If the answer to any of the following questions is "YES", please describe the condition or situation that prompted your answer, giving the date and doctor clearance in Part C.

****NOTE: Injuries within the last year only.**

- | | | | | |
|-----|---|-----|----|------------|
| 1. | Any injuries requiring medical attention including concussion or loss of consciousness? | YES | NO | DATE _____ |
| 2. | Any illness lasting more than 5 days? | YES | NO | DATE _____ |
| 3. | Currently taking medication or under the care of a physician? | YES | NO | DATE _____ |
| 4. | Any feelings of faintness, dizziness, fatigue, or chest pain after exercise or exertion? | YES | NO | DATE _____ |
| 5. | Change in wearing glasses or contact lenses? | YES | NO | DATE _____ |
| 6. | Any fractures or surgical procedures? | YES | NO | DATE _____ |
| 7. | Any treatment in a hospital or emergency room? | YES | NO | DATE _____ |
| 8. | Developed any allergies, asthma, exercise induced asthma or reactions to medication? | YES | NO | DATE _____ |
| 9. | Any chronic disease? (Diabetes, bleeding disorder, seizures) | YES | NO | DATE _____ |
| 10. | Problems with heat exhaustion/heat fatigue? | YES | NO | DATE _____ |
| 11. | Absence of or the significant impairment of one of a pair of organs? (kidney, eye, ear, testicle) | YES | NO | DATE _____ |
| 12. | Any history of sudden death in a family member under the age of 50? | YES | NO | DATE _____ |

PART C - TO BE COMPLETED BY PARENT OR GUARDIAN

Describe the condition or situation that caused you to answer "YES" to any question in PART B.

PART D - PARENTAL PERMISSION

I, the undersigned, clearly understand these questions are asked in order to decide if my child can safely participate on the athletic team named in Part A of this form. The answers are correct as of this date and he/she has my permission to participate.

SIGNED _____ DATE _____

Student Name _____

TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE:

Sports Participation (check)

___ Approved _____ Referred to School Physician

Signed _____ Date ____/____/____
 School Health Office

If referred to the School Physician (check):

___ Requalified _____ Disqualified

Signed _____ Date ____/____/____
 School Physician

PLEASE RETURN TO THE HEALTH OFFICE



Dear Parents,

Your child has expressed a desire to participate in athletic competition with other schools during the coming season. The activity and level of competition is indicated below.

If your child becomes a member of a team, he/she will represent Schalmont High School in several communities, and we are anxious that there be understanding prior to participation.

Attendance at practice sessions and contests is compulsory, unless his/her coach excuses the student. School citizenship demonstrated by class conduct and conformance to school regulations, is as important as conduct at practice sessions and games. Sportsmanship will be emphasized, and conduct unbecoming a student will not be tolerated.

A physical examination by a physician must be submitted and reviewed by the school nurse prior to participation. With few exceptions, the law states that one physical examination will suffice for the entire year; however, your permission for participation will be requested prior to each sports season.

If your child is injured, it is his/her responsibility to report the injury to the coach, who will in turn notify the school nurse. Insurance forms are available from the nurse and must be requested by your child.

The school district carries a supplemental insurance plan to cover incidents that occur in school related activities. If an incident requires medical attention, the parent must submit his or her own insurance first. If the claim is not payable or in excess of the parent's coverage, the supplemental insurance forms are available in the health office. Please direct all questions regarding insurance to Joseph Lenz in the District Office at 355-9200 ext. 4002.

It is important that all the information below is completed so that, in the event of an injury, the proper individuals may be contacted immediately.

Sincerely,

John Gallo, Director of Athletics

I have read the above letter and agree to abide by the contents.

Player's Signature _____ Age _____

I give my son/daughter permission to participate in _____
(extramural/interschool sport)

Date _____ Parent Signature _____

Home Phone _____ Cell Phone _____

Emergency Contact/Relationship _____ Phone _____

Family Dentist and Phone _____

Family Physician and Phone _____

District Office
4 Sabre Drive
Schenectady, NY 12306
(518) 355-9200
FAX: (518) 355-9203

Superintendent of Schools
Dr. Carol A. Pallas
Ext. 4001

Business Office
Joseph Lenz
Business Administrator
Ext. 4002

Special Education Office
Shari Lontrato
Director of Pupil
Personnel Services
Ext. 4018

High School
1 Sabre Drive
Schenectady, NY 12306

(518) 355-6110
FAX: (518) 355-8720

Middle School
2 Sabre Drive
Schenectady, NY 12306
(518) 355-6255
FAX: (518) 355-5329

Jefferson Elementary School
100 Princetown Road
Schenectady, NY 12306
(518) 355-1342
FAX: (518) 357-0293

Transportation Office
401 Duanesburg Road
Schenectady, NY 12306
(518) 355-9200 Ext. 4201
FAX: (518) 355-0972

STUDENT HEALTH EXAMINATION FORM (To be completed 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, 2, 4, 7 & 10, interscholastic sports and working papers.

Name: _____ DOB: _____ Gender: M F
 School: _____ Grade: No Grade Exam Date: _____

IMMUNIZATIONS

Immunization record attached
 Immunizations reported on NYSIS
 No immunizations received today

Immunizations received today:
 Will return on: _____ to receive: _____

HEALTH HISTORY

Asthma: Intermittent Persistent Asthma Action Plan Attached
 Diabetes: Type I Type 2 Hyperlipidemia Hypertension Diabetes Medical Mgmt Plan Attached
 Seizures Type: _____ Last Occurrence: _____ Emergency Care Plan Attached
 Allergies: Non Life-Threatening Life-Threatening Emergency Care Plan Attached
 Type: Food Insect Latex Medication Seasonal/Environmental Other:
 Allergen(s): _____
 Hx of Anaphylaxis: Last occurrence: _____ Previous symptoms: _____
 Treatment prescribed: None Antihistimine Epinephrine Autoinjector

Significant Medical/Surgical Information:	Diagnostic Tests	Positive	Negative	Not Done	Date
	Sickle Cell Screen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	PPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Elevated Lead:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Vision one eye only One functioning kidney One testicle Concussion - Last occurrence: _____

PHYSICAL EXAMINATION

Height: _____ Weight: _____ BP: _____ Pulse: _____ Respirations: _____

Scoliosis: Negative Positive
 Degree of deviation: _____
 Angle of trunk rotation via scoliometer: _____

Weight Status Category (BMI Percentile):	Vision		Respirations:		Referral
	Right	Left	Right	Left	
<input type="checkbox"/> <5th <input type="checkbox"/> 5 th - 49 th <input type="checkbox"/> 85 th - 94 th <input type="checkbox"/> 95 th - 98 th <input type="checkbox"/> 50 th - 84 th <input type="checkbox"/> 99 th & higher	Distance acuity				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Distance acuity with lenses				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Vision - near vision				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Vision - color perception		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Hearing		Right	Left	Referral
	<input type="checkbox"/> 20 db sweep screen both ears or				<input type="checkbox"/> Yes <input type="checkbox"/> No

Check developmental stage (ONLY for Athletic Placement Process for 7th & 8th graders): Tanner: I II III IV V

SYSTEM REVIEW AND EXAM ENTIRELY NORMAL Additional information attached
 Specify any abnormalities: _____

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

- Full Activity** without restrictions including Physical Education and Athletics.
- Restrictions/Adaptations.** Please base restrictions/modifications on the following Interscholastic Sports Categories.
 - No Contact Sports** includes: basketball, baseball, field hockey, ice hockey, lacrosse, soccer, football, softball, volleyball, competitive cheerleading and wrestling
 - No Non-Contact Sports** includes: archery, bowling, cross-country, golf, gymnastics, rifle, swimming and diving, skiing, tennis, track & field, fencing, badminton
 - Other Specific Restrictions:**

Accommodations / Protective Equipment:	<input type="checkbox"/> Athletic Cup	<input type="checkbox"/> Insulin Pump/Insulin Sensor	<input type="checkbox"/> Pacemaker
	<input type="checkbox"/> Brace/Orthotic	<input type="checkbox"/> Medical /Prosthetic Device	<input type="checkbox"/> Sports Safety Goggles
	<input type="checkbox"/> Hearing Aides	<input type="checkbox"/> Other:	

MEDICATION HISTORY (optional)

Please list names of prescribed or OTC medications used on a routine basis at home

PROVIDER REQUEST FOR MEDICATION REQUIRED DURING SCHOOL/SCHOOL SPONSORED EVENTS - VALID 1 YEAR

Independent Carry and Use Option: NYS law requires both provider attestation that the student has demonstrated they can effectively self-administer inhaled respiratory rescue medication, epinephrine autoinjector, insulin, glucagon and diabetes supplies, or other medications requiring rapid administration along with parent/guardian permission to allow this option in schools.

- Required Independent Carry and Use Attestation documentation is attached.**

Diagnosis	ICD Code	Medication Name	Dose	Route	Time

REQUIRED PARENT/GUARDIAN PERMISSION FOR MEDICATION USE AT SCHOOL

Parent/Guardian Permission: I request the school nurse give the medications listed on this plan; or after the nurse determines my child can take their own medications, trained staff may assist my child to take their own medications. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with staff caring for my child

Parent/Guardian Signature: _____

HEALTH CARE PROVIDER

All information contained herein is valid through the last day of the month for 12 months from the date below.

Medical Provider Signature: _____	Date: _____
Provider Name: (please print) _____	Phone #: () _____
Provider Address: _____	Fax #: () _____

Return to:

School Nurse: _____	School: _____
Phone #: () _____	Fax: () _____
	Date: _____

Concussion Information Sheet for Students and Parents

The following recommendations are standard for all students who suffer from a head injury and are designed to help speed your recovery. Your careful attention to them can also prevent prolonged recovery and further injury. The typical recovery period for a concussion is 7 to 10 days.

- Avoid physical activity – you should not participate in physical education or sports participation until you are headache free for one week. This includes weight training, running, exercising and heavy lifting.
- Get lots of rest. Be sure to get enough sleep at night – no late nights. Keep the same bedtime on the weekdays and weekends. Drink lots of fluids and eat carbohydrates or protein to maintain appropriate blood sugar levels
- Take daytime naps or rest breaks if you feel fatigued or the onset of a headache
- Limit activities that require a lot of thinking or concentration. These activities can make your symptoms worse. This may include limiting class work, homework and job related activity. Avoid prolonged computer use, video gaming, television watching, text messaging, telephone use.
- During recovery, it is normal to feel frustrated and sad when you do not feel right and you cannot be as active as usual.
- Seek re-evaluation as your symptoms will help guide recovery.
- Academic Participation

Because recovering from a concussion can be a gradual process and school work continues while recovery is taking place, it is necessary for students, parents and school personnel to be aware of and consider the following symptoms that a student may demonstrate during recovery:

- Increased difficulty paying attention or concentrating
- Increased problems remembering or learning new information
- Longer time needed to complete tasks or assignments Greater irritability, less able to cope with stress
- Headaches and fatigue that worsens when doing school work

These symptoms are normal, to be expected, and temporary.

Physical Activity and Sport Participation

It is important to avoid all physical activity, in school and out of school, in particular any physical activity that carries a risk of head injury. The likelihood of sustaining a second head injury is greater during the recovery phase of a concussion. Rapid or early return to sports and play puts you at risk for Second Impact Syndrome which can lead to severe and possibly lethal outcomes. Therefore, it is necessary to follow these recommendations for returning to sports/play:

- You should NEVER return to play if you have any concussion symptoms (see above). This includes symptoms at rest and while doing any physical or mental activity. Be sure the PE teacher, coach and athletic trainer are aware of your injury and ongoing symptoms.
- It is normal to feel frustrated, sad and even angry because you cannot return to sports right away.
- As with any injury, a full recovery will reduce the chances of getting hurt again. It is better to miss one or two games than the whole season.

Requirements for Academic Accommodations during Recovery

1. Medical evaluation and side two of this form is completed by student's physician
2. Parental authorization for school nurse and medical advisor to exchange information with student's physician.
3. Student has not been cleared to resume game play (athletics) or other contact/strenuous physical activity.

Physician Evaluation

Date of First Evaluation: _____

Time of Evaluation: _____

Date of Second Evaluation: _____

Time of Evaluation: _____

Symptoms Observed:	First Doctor Visit		Second Doctor Visit	
	Yes	No	Yes	No
Dizziness	Yes	No	Yes	No
Headache	Yes	No	Yes	No
Tinnitus	Yes	No	Yes	No
Nausea	Yes	No	Yes	No
Fatigue	Yes	No	Yes	No
Drowsy/Sleepy	Yes	No	Yes	No
Sensitivity to Light	Yes	No	Yes	No
Sensitivity to Noise	Yes	No	Yes	No
Anterograde Amnesia (after impact)	Yes	No	N/A	N/A
Retrograde Amnesia (backwards in time from impact)	Yes	No	N/A	N/A

* Please indicate yes or no in your respective columns. First Doctor use column 1 and second Doctor use column 2.

First Doctor Visit:

Did the athlete sustain a concussion? (Yes or No) (one or the other must be circled)

** Post-dated releases will not be accepted. The athlete must be seen and released on the same day.

Please note that if there is a history of previous concussion, then referral for professional management by a specialist or concussion clinic should be strongly considered.

Additional Findings/Comments: _____

Recommendations/Limitations: _____

Signature: _____ Date: _____

Print or stamp name: _____ Phone number: _____

Second Doctor Visit:

*** Athlete must be completely symptom free in order to begin the return to play progression. If athlete still has symptoms more than seven days after injury, referral to a concussion specialist/clinic should be strongly considered.

Please check one of the following:

- Athlete is asymptomatic and is ready to begin the return to play progression.
- Athlete is still symptomatic more than seven days after injury.

Signature: _____ Date: _____

Print or stamp name: _____ Phone number: _____