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 that 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

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

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____

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 NYSIIS
☐ 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	☐	☐	☐	
	PPD	☐	☐	☐	
	Elevated Lead:	☐	☐	☐	

☐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:

Vision	**Right**	**Left**	***Referral***
Distance acuity			☐Yes ☐No
Distance acuity with lenses			☐Yes ☐No
Vision - near vision			☐Yes ☐No
Vision - color perception	☐ Pass	☐ Fail	☐Yes ☐No
Hearing	**Right**	**Left**	***Referral***
☐ 20 db sweep screen both ears or			☐Yes ☐No

Weight Status Category (BMI Percentile):

☐ <5th ☐ 85th - 94th
☐ 5th - 49th ☐ 95th - 98th
☐ 50th - 84th ☐ 99th & higher

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:	☐Athletic Cup	☐Insulin Pump/Insulin Sensor	☐Pacemaker
	☐Brace/Orthotic	☐Medical /Prosthetic Device	☐Sports Safety Goggles
	☐Hearing Aides	☐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	
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:____________