Physical: _____ **Pulses:** _____

THE ENLARGED CITY SCHOOL DISTRICT OF TROY, NEW YORK

Troy High School 518-328-5425 Fax 518-271-5174. Troy Middle School 518-328-5325 Fax 518-271-5175

STUDENT PARTICIPATION AND PARENTAL SPORT APPROVAL

Name of student: _____
Last **First** **Initial**

Date of Birth: _____ **Male** _____ **Female** _____ **Current Grade:** _____

This application to compete in interscholastic athletics for the above High School/Middle School is entirely voluntary on my part and is made with the understanding that I have not violated any of the eligibility rules and regulations of the State Association.

Signature of Student: _____ **Date:** _____

	FALL	WINTER	SPRING
THS	X-Country Golf Football Soccer (boys/girls) Cheerleading Swimming (girls) Tennis (girls) Volleyball	Basketball (boys/girls) Bowling Indoor Track (boys/girls) Cheerleading	Baseball (boys) Softball (girls) Lacrosse Spring track (boys/girls) Tennis (boys)
TMS	Football Soccer (boys/girls) Volleyball	Basketball (boys/girls) Swimming (boys/girls)	Spring track (boys/girls)

Above is a list of sports potentially available for the school year (TMS or THS). Write down on the line provided, all sports you will allow your child to participate in. Selected sports MUST be written down (not checked off or circled)

_____

PARENT/GUARDIAN PERMISSION FOR SPORT

I hereby give my consent for the above High School/Middle School student to engage in State Association approved athletic activities as a representative of his/her High School/Middle School, EXCEPT those stated on the reverse side of this form by the examining physician. I also give my consent for the above student to accompany the team as a member on its out of town trips.

Signature of Parent/Guardian: _____ **Date:** _____

Address: _____ **Home Telephone #** _____

Work Telephone # _____ **Cellular Telephone #** _____

Complete form IN INK and return to the Health Office

INCOMPLETE FORMS WILL NOT BE PROCESSED

THE ENLARGED CITY SCHOOL DISTRICT OF TROY, NEW YORK

PHYSICAL EXAMINATION FORM

(TO BE FILLED OUT BY THE PHYSICIAN)

Cooperatively prepared by the National Federation of State High School Athletic Associations and the Committee on Medical Aspects of Sports of the American Medical Association. Medical examination may be scheduled at any time during the school year and shall be valid for a period of twelve (12) continuous months.

Name_____ **Age**_____
Last **First** **M.I.**

Height_____ **Weight**_____ **BMI** _____

Significant past illness or injury _____

Eyes _____ **R 20/ L 20/ Ears** _____ **R /15 L /15 Blood Pressure** _____

Respiratory _____ **Cardiovascular** _____

Liver _____ **Spleen** _____ **Hernia** _____

Musculo-skeletal _____

Neurological _____ **Genitalia** _____

Laboratory: Urinalysis _____ **Other** _____

Allergies _____

Comments _____

_____

Completed Immunizations: Polio (date)_____ **Tetanus (date)**_____

Other:_____

_____

I certify that I have on this date examined this pupil and find him/her physically able to compete in supervised activities, except the following: _____

Weight loss permitted to make lower weight class: Yes _____ **No** _____ **If yes, may lose** _____ **lbs.**

Date of Examination _____ **Examining Physician** _____

Physician's Address_____ **Telephone** _____

THE ENLARGED CITY SCHOOL DISTRICT OF TROY, NEW YORK

INTERVAL HEALTH HISTORY FOR SPORTS PARTICIPATION

At the beginning of each season, a Health History review must be completed within 30 days prior to start of tryout sessions or practice, unless the athlete received a full medical exam within those 30 days.

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Student_____Age_____Female_____Male_____

Grade_____Date of Birth_____Sport_____

NOTE: PLEASE MARK YES or NO (X) FOR EACH QUESTION. IF "YES" EXPLAIN WITH DATE OF ONSET

"Yes" to any of these questions does not mean automatic disqualification from the athletic activity indicated above. All forms will require a review and approval by the school physician before the student can report to tryout sessions or practice. This form will be held in the school health office and will be kept confidential.

Has your child ever had the following?

HEALTH HISTORY	No	Yes	EXPLAIN WITH DATE
Allergies/Hay Fever			
Bee Sting Allergy			
Asthma			
Anemia			
Arthritis			
Bladder/Kidney Problem or Injury			
Convulsions/Seizures			
Fainting spells			
Diabetes			
Ear Problems/Hearing Loss			
Eye Problems/Vision Loss			
Injury to the spleen			
Elevated Blood Pressure			
Headaches			
Head Injury/Concussion			
Heart Problem/Murmur/Chest Pains			
Nose Bleeds/Frequent or Severe			
Back pain/Injury			
Fracture/Dislocation/Sprain			
Neck Injury			
Rheumatic Fever			
Stomach Ulcer			
Loss of hearing in one or both ears			
Loss of consciousness or loss of memory from a blow to the head			
Severe uncorrectable loss of vision in one or both eyes			
Loss or absence of one kidney			

HEALTH HISTORY	No	Yes	EXPLAIN WITH DATE
Loss or absence of one testicle			
Loss or absence of one eye			
Illness for five (5) consecutive days			
Taken medication in the past year			
Fainting episodes during exercise			
Illness or injury which required treatment in a hospital as an inpatient/outpatient			
Orthodontic Appliances			
Capped Teeth			
Wear contact lenses for sports			
Wear glasses for sports			
Is your child under medical care now?			
Has there ever been a sudden death of a member of the family under fifty (50) years of age?			
Since your child's last physical examination, has your child had any injury or medical illness?			
Do you have any concerns about your child's health or questions you would like to discuss with a doctor?			

I agree with the above answers and consent to the participation of my child in the interscholastic program of his/her school, including practice sessions and travel to and from athletic contests. I also agree to emergency medical treatment as deemed necessary by the physicians designated by school authorities.

Parent/Guardian Signature_____Date_____

FOR SCHOOL PHYSICIAN USE ONLY

This certifies that_____is physically qualified to participate in the following categories of competition during this school year.

Any unmarked categories indicate disqualification for the particular group of sports activities.

Contact/Collision	Limited Contact/Impact	Strenuous Non-Contact	Non-Strenuous Non-Contact
Ice Hockey	Baseball, Basketball	X-Country	
Football	Diving	Track & Field	Bowling
Lacrosse	Cheerleading	Swimming	Golf
Soccer	Softball, Volleyball	Tennis	

School Physician's Signature_____Date_____

THE ENLARGED CITY SCHOOL DISTRICT OF TROY, NEW YORK

1950 Burdett Avenue Troy, NY 12180
Paul Reinisch – Director of Health, Physical Education, Athletics, Safety
Phone# 518-328-5407 THS Fax#518-271-5174 TMS Fax# 518-271-5175

PARENT/GUARDIAN CONSENT
ATHLETE PARTICIPATION & MEDICAL TREATMENT

Dear Parent/Guardian,

Your child has expressed a desire to participate in our interscholastic sports program. It is important that you and your child understand the goals of the program and agree to abide by the rules established by the district for the benefit of those who participate.

WARNING: PARTICIPATION IN ATHLETICS INCLUDES A RISK OF SERIOUS INJURY, PERMANENT PARALYSIS, INFECTIOUS DISEASE OR DEATH. ATHLETIC PARTICIPATION WILL ALSO INVOLVE TRAVEL IN SCHOOL DISTRICT VEHICLES. NO TRAVEL WILL BE PERMITTED OTHER THAN IN DISTRICT VEHICLES WITHOUT SPECIAL PERMISSION. ALL TRAVEL INCLUDES RISK OF INJURY.

1. **Interscholastic sports are a part of a broad extracurricular program designed to teach students certain skills and reinforce concepts of self-worth (achievement), cooperative efforts (teamwork), and ethical decision making (sportsmanship.)**

2. **In order to try out for a sport, each athlete is required to have a complete student packet and current physical on file in the Health Office**

3. **School Insurance for the medical treatment of sport-related injuries is applicable only after the parents' health insurance has been used. ALL BILLS MUST BE SUBMITTED TO YOUR INSURANCE COMPANY FIRST – (THE SCHOOL INSURANCE IS SECONDARY INSURANCE)**

4. **Within the first three team meetings, the coach will explain the attendance, training, and athletic code rules, as well as eligibility rules for participation. In addition to the strict observance of these rules, your child will be expected to continue to meet all regular school obligations of citizenship and academic achievement.**

5. **School equipment issued to your child for participation is his/her responsibility and must be returned promptly upon request. Reimbursement from the student will be expected for loss or destruction beyond ordinary wear and tear.**

6. **IN THE EVENT THAT YOUR CHILD BECOMES SICK OR RECEIVES ANY INJURY DURING ATHLETIC PARTICIPATION, ALL REASONABLE EFFORTS WILL BE MADE TO CONTACT YOU AND OBTAIN ANY REQUIRED CONSENT FOR MEDICAL CARE. IN SITUATIONS WHERE YOU CANNOT BE CONTACTED FOR CONSENT TO TREATMENT AND SUCH DELAY CREATES A RISK TO YOUR CHILD'S LIFE OR HEALTH, THE DISTRICT REPRESENTATIVES WILL USE THE AUTHORITY YOU GRANT THEM BY THIS FORM TO OBTAIN APPROPRIATE MEDICAL CARE AND TREATMENT FOR YOUR CHILD.**

Paul Reinisch, Director

As the parent/guardian of _____ **Date of Birth** _____
(name of student)
I hereby give my permission to participate in _____
(name of sport)

Signature of parent/guardian _____ **Date:** _____

Telephone: Home _____ **Work** _____ **Cell** _____