Physical: _____

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) Softball (girls) Baseball (boys)

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

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_____

HEALTH OFFICE FORM NOTES:

_____

_____

_____

_____

_____

FORM RECEIVED: _____

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/Does your child:

General Health Concerns	No	Yes	EXPLAIN WITH DATE
Ever been restricted by a doctor, physician assistant or nurse practitioner from sports participation for any reason?			
Have an ongoing medical condition? ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Sickle Cell disease or trait ☐ Other _____			
Ever had surgery?			
Ever spent a night in a hospital?			
Been diagnosed with Mononucleosis within the last month?			
Have only one functioning kidney?			
Have a bleeding disorder?			
Have any problems with their hearing or wears hearing aid(s)?			
Have any problems with their vision or has vision in only one eye?			
Wear glasses or contacts?			
Allergies	**No**	**Yes**	**EXPLAIN WITH DATE**
Have a life threatening allergy? ☐ Food ☐ Latex ☐Pollen ☐ Insect bite/sting ☐Medicine ☐ Other_____			
Carry an epinephrine auto-injector?			
Breathing (Respiratory) Health	**No**	**Yes**	**EXPLAIN WITH DATE**
Ever complained of getting more tired or short of breath than their friends during exercise?			
Wheeze or cough frequently during or after exercise?			
Ever been told by a healthcare provider they have Asthma?			
Use or Carry an inhaler or nebulizer?			
Concussion/ Head injury History	**No**	**Yes**	**EXPLAIN WITH DATE**
Ever had a hit to the head that caused headache, dizziness, nausea, confusion or been told they have a concussion?			
Ever had a head injury or concussion?			
Ever had headaches with exercise?			
Ever had unexplained seizures?			
Currently receive treatment for a seizure disorder or epilepsy?			

Devices/Accommodations	No	Yes	EXPLAIN WITH DATE
Use a brace, orthotic or other device?			
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.			
Wear protective eyewear such as goggles or a face shield?			
Heart Health	**No**	**Yes**	**EXPLAIN WITH DATE**
Ever passed out during or after exercise?			
Ever complained of lightheadedness or dizziness during or after exercise?			
Ever complained of chest pain, tightness, or pressure during or after exercise?			
Ever complained of fluttering in their chest, skipped beats, or their heart racing or do they have a pacemaker?			
Ever had a test by their medical provider for their heart (e.g. EKG, echocardiogram stress test)?			
Ever been told they have a heart condition or problem by a physician? If so, check all that apply: ☐ Kawasaki Disease ☐ Heart infection ☐ heart murmur ☐High Cholesterol ☐ High Blood Pressure ☐ Low Blood Pressure ☐ Other _____			
Injury History	**No**	**Yes**	**EXPLAIN WITH DATE**
Ever been diagnosed with a stress fracture?			
Ever been unable to move their arms and legs, or had tingling, numbness or weakness after being hit or falling?			
Ever had an injury, pain, or swelling of joint that caused them to miss practice or a game?			
Have a bone, muscle, or joint injury that bothers them?			
Have joints become painful, swollen warm, or red with use?			
Skin Health	**No**	**Yes**	**EXPLAIN WITH DATE**
Currently have any rashes, pressure sores, or other skin problems?			
Have had a herpes or MRSA skin infection?			
Stomach Health	**No**	**Yes**	**EXPLAIN WITH DATE**
Ever become ill while exercising in hot weather?			
Have a special diet or have to avoid certain foods?			
Have to worry about their weight?			
Have stomach problems?			
Ever have an eating disorder?			
Family History	**No**	**Yes**	**EXPLAIN WITH DATE**
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?			

Females Only	Males Only
Begun having her period? ☐ Yes ☐ No	Have only one testicle? ☐ Yes ☐ No
Age periods began: _____	Have groin pain or a bulge or hernia in the groin? ☐ Yes ☐ No
Have regular periods? ☐ Yes ☐ No	
Date of last menstrual period:	

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_____

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** _____