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:** _____

PARENT/GUARDIAN PERMISSION FOR SPORT

TMS: ***Fall*** – Football; Soccer (boys/girls); Volleyball ***Winter***: Basketball (boys/girls); Swimming (boys/girls)
Spring – Spring track; Softball; Baseball; Lacrosse
TMS Sport selected: _____

THS: ***Fall*** – X-Country; Golf; Football; Soccer (boys/girls); Cheerleading; Swimming (girls); Tennis (girls); Volleyball
Winter – Basketball (boys/girls); Bowling; Indoor track (boys/girls); Cheerleading; Swimming (boys)
Spring – Baseball; Softball; Lacrosse; Spring track; Tennis (boys)
THS Sport selected: _____

To my knowledge, there is no medical reason that my son/daughter cannot participate in interscholastic sports. We have read and understand all athletic training rules and regulations.

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

Enlarged City School District of Troy, New York

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Student Name: **DOB:**

MUST be completed and signed by Parent/Guardian - Give details to any YES answers on page 2

Does or Has Your Child

General Health	No	Yes
Ever been restricted by a health care provider from sports participation for any reason?	☐	☐
Ever had surgery?	☐	☐
Ever spent the 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 hearing or have congenital deafness?	☐	☐
Have any problems with vision or only have vision in one eye?	☐	☐
Have an ongoing medical condition?	☐	☐
If yes, check all that apply: ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Sickle cell trait or disease ☐ Other:		
Have Allergies?	☐	☐
If yes, check all that apply ☐ Food ☐ Insect Bite ☐ Latex ☐ Medicine ☐ Pollen ☐ Other:		
Ever had anaphylaxis?	☐	☐
Carry an epinephrine auto-injector?	☐	☐
Brain/Head Injury History	**No**	**Yes**
Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told they had a concussion?	☐	☐
Receive treatment for a seizure disorder or epilepsy?	☐	☐
Ever had headaches with exercise?	☐	☐
Ever had migraines?	☐	☐
Breathing	**No**	**Yes**
Ever complained of getting extremely tired or short of breath during exercise?	☐	☐
Use or carry an inhaler or nebulizer?	☐	☐
Wheeze or cough frequently during or after exercise?	☐	☐
Ever been told by a health care provider they have asthma or exercise-induced asthma?	☐	☐

Does or Has Your Child

Devices / Accommodations	No	Yes
Use a brace, orthotic, or another device?	☐	☐
Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)?	☐	☐
Wear protective eyewear, such as goggles or a face shield?	☐	☐
Wear a hearing aid or cochlear implant?	☐	☐
Let the coach/school nurse know of any device used. Not required for contact lenses or eyeglasses.		
Digestive (GI) Health	**No**	**Yes**
Have stomach or other GI problems?	☐	☐
Ever had an eating disorder?	☐	☐
Have a special diet or need to avoid certain foods?	☐	☐
Are there any concerns about your child's weight?	☐	☐
Injury History	**No**	**Yes**
Ever been unable to move their arms or legs or had tingling, numbness, or weakness after being hit or falling?	☐	☐
Ever had an injury, pain, or swelling of a joint that caused them to miss practice or a game?	☐	☐
Have a bone, muscle, or joint that bothers them?	☐	☐
Have joints that become painful, swollen, warm, or red with use?	☐	☐
Ever been diagnosed with a stress fracture?	☐	☐
Heart Health	**No**	**Yes**
Ever complained of:		
Ever had a test by a health care provider for their heart (e.g., EKG, echocardiogram, stress test)?	☐	☐
Lightheadedness, dizziness, during or after exercise?	☐	☐
Chest pain, tightness, or pressure during or after exercise?	☐	☐
Fluttering in the chest, skipped heartbeats, heart racing?	☐	☐

Student Name:	**DOB:**
MUST be completed and signed by Parent/Guardian - Give details to any YES answers below	

DOES OR HAS YOUR CHILD		
Heart Health	**No**	**Yes**
Ever been told by a health care provider they have or had a heart or blood vessel problem?	☐	☐

If yes, check all that apply:

☐ Chest Tightness or Pain ☐ Heart infection
☐ High Blood Pressure ☐ Heart Murmur
☐ High Cholesterol ☐ Low Blood Pressure
☐ New fast or slow heart rate ☐ Kawasaki Disease
☐ Has implanted cardiac defibrillator (ICD)
☐ Has a pacemaker
☐ Other:

FEMALES ONLY	NO	YES
Have regular periods?	☐	☐

MALES ONLY	NO	YES
Have only one testicle?	☐	☐
Have groin pain or a bulge, or a hernia?	☐	☐

DOES OR HAS YOUR CHILD		
SKIN HEALTH	**NO**	**YES**
Currently have any rashes, pressure sores, or other skin problems?	☐	☐
Ever had a herpes or MRSA skin infection?	☐	☐
COVID-19 Information	**No**	**Yes**
Has your child ever tested positive for COVID-19?	☐	☐
If **NO, STOP.** Go to Family Heart Health History. If **YES,** answer questions below:		
Date of positive COVID test:		
Was your child symptomatic?	☐	☐
Did your child see a health care provider for their COVID-19 symptoms?	☐	☐
Was your child hospitalized for COVID?	☐	☐
Was your child diagnosed with Multisystem Inflammatory Syndrome (MISC)?	☐	☐

FAMILY HEART HEALTH HISTORY

A relative has/had any of the following:

Check all that apply:

☐ Enlarged Heart/ Hypertrophic Cardiomyopathy/ Dilated Cardiomyopathy
☐ Arrhythmogenic Right Ventricular Cardiomyopathy?
☐ Heart rhythm problems, long or short QT interval?
☐ Brugada Syndrome?
☐ Catecholaminergic Ventricular Tachycardia?
☐ Marfan Syndrome (aortic rupture)?
☐ Heart attack at age 50 or younger?
☐ Pacemaker or implanted cardiac defibrillator (ICD)?

A family history of:

☐ Known heart abnormalities or sudden death before age 50?
☐ Structural heart abnormality, repaired or unrepaired?
☐ Unexplained fainting, seizures, drowning, near drowning, or car accident before age 50?

Explain YES answers here:

Parent/Guardian Signature: Date: