

**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); Flag football (girls)**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**Ice Hockey  
Football  
Lacrosse  
Soccer**Limited Contact/Impact**Baseball, Basketball  
Diving  
Cheerleading  
Softball, Volleyball**Strenuous Non-Contact**X-Country  
Track & Field  
Swimming  
Tennis**Non-Strenuous  
Non-Contact**Bowling  
Golf

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**

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

**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?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>
Been diagnosed with mononucleosis within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
Have only one functioning kidney?	<input type="checkbox"/>	<input type="checkbox"/>
Have a bleeding disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Have any problems with hearing or have congenital deafness?	<input type="checkbox"/>	<input type="checkbox"/>
Have any problems with vision or only have vision in one eye?	<input type="checkbox"/>	<input type="checkbox"/>
Have an ongoing medical condition?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, check all that apply:		
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Seizures	<input type="checkbox"/> Sickle cell trait or disease	
<input type="checkbox"/> Other:		
Have Allergies?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, check all that apply		
<input type="checkbox"/> Food	<input type="checkbox"/> Insect Bite	<input type="checkbox"/> Latex
<input type="checkbox"/> Pollen	<input type="checkbox"/> Other:	<input type="checkbox"/> Medicine
Ever had anaphylaxis?	<input type="checkbox"/>	<input type="checkbox"/>
Carry an epinephrine auto-injector?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
Receive treatment for a seizure disorder or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had migraines?	<input type="checkbox"/>	<input type="checkbox"/>
BREATHING	NO	YES
Ever complained of getting extremely tired or short of breath during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Use or carry an inhaler or nebulizer?	<input type="checkbox"/>	<input type="checkbox"/>
Wheeze or cough frequently during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Ever been told by a health care provider they have asthma or exercise-induced asthma?	<input type="checkbox"/>	<input type="checkbox"/>

DOES OR HAS YOUR CHILD		
DEVICES / ACCOMMODATIONS	NO	YES
Use a brace, orthotic, or another device?	<input type="checkbox"/>	<input type="checkbox"/>
Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
Wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
Wear a hearing aid or cochlear implant?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Let the coach/school nurse know of any device used. Not required for contact lenses or eyeglasses.</b>		
DIGESTIVE (GI) HEALTH	NO	YES
Have stomach or other GI problems?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Have a special diet or need to avoid certain foods?	<input type="checkbox"/>	<input type="checkbox"/>
Are there any concerns about your child's weight?	<input type="checkbox"/>	<input type="checkbox"/>
INJURY HISTORY	NO	YES
Ever been unable to move their arms or legs or had tingling, numbness, or weakness after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had an injury, pain, or swelling of a joint that caused them to miss practice or a game?	<input type="checkbox"/>	<input type="checkbox"/>
Have a bone, muscle, or joint that bothers them?	<input type="checkbox"/>	<input type="checkbox"/>
Have joints that become painful, swollen, warm, or red with use?	<input type="checkbox"/>	<input type="checkbox"/>
Ever been diagnosed with a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>
Lightheadedness, dizziness, during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain, tightness, or pressure during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Fluttering in the chest, skipped heartbeats, heart racing?	<input type="checkbox"/>	<input type="checkbox"/>

**Student Name:**

**DOB:**

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

DOES OR HAS YOUR CHILD		
<b>Heart Health</b>	No	Yes
Ever been told by a health care provider they have or had a heart or blood vessel problem?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, check all that apply:		
<input type="checkbox"/> Chest Tightness or Pain	<input type="checkbox"/> Heart infection	
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Murmur	
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Low Blood Pressure	
<input type="checkbox"/> New fast or slow heart rate	<input type="checkbox"/> Kawasaki Disease	
<input type="checkbox"/> Has implanted cardiac defibrillator (ICD)		
<input type="checkbox"/> Has a pacemaker		
<input type="checkbox"/> Other:		
<b>FEMALES ONLY</b>	No	Yes
Have regular periods?	<input type="checkbox"/>	<input type="checkbox"/>
<b>MALES ONLY</b>	No	Yes
Have only one testicle?	<input type="checkbox"/>	<input type="checkbox"/>
Have groin pain or a bulge, or a hernia?	<input type="checkbox"/>	<input type="checkbox"/>

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

FAMILY HEART HEALTH HISTORY	
A relative has/had any of the following: Check all that apply:	
<input type="checkbox"/> Enlarged Heart/ Hypertrophic Cardiomyopathy/ Dilated Cardiomyopathy	<input type="checkbox"/> Brugada Syndrome?
<input type="checkbox"/> Arrhythmogenic Right Ventricular Cardiomyopathy?	<input type="checkbox"/> Catecholaminergic Ventricular Tachycardia?
<input type="checkbox"/> Heart rhythm problems, long or short QT interval?	<input type="checkbox"/> Marfan Syndrome (aortic rupture)?
	<input type="checkbox"/> Heart attack at age 50 or younger?
	<input type="checkbox"/> Pacemaker or implanted cardiac defibrillator (ICD)?
A family history of:	
<input type="checkbox"/> Known heart abnormalities or sudden death before age 50?	<input type="checkbox"/> Structural heart abnormality, repaired or unrepaired?
<input type="checkbox"/> Unexplained fainting, seizures, drowning, near drowning, or car accident before age 50?	

Explain YES answers here:

Parent/Guardian Signature:

Date: