NEWBURGH FREE ACADEMY

Department of Physical Education, Health and Athletics

Director of Physical Education, Health & Athletics
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ATHLETIC PLACEMENT PROCESS

PARENT/GUARDIAN PERMISSION

PARENT/GUARDIAN STATEMENT:

I have read the attached letter and I understand the purpose and eligibility implications of the Athletic Placement Process.
My son/daughter (name): ____ has my permission to undergo the evaluation process and to participate in this program. I understand that the determination of physical maturity is a private examination involving inspection of breasts and genitals and will be done by a licensed school health professional, and I give my permission for the examination. Upon approval of the district medical director, he/she may proceed to the physical fitness and skill assessments. I understand that passing the evaluation process does not guarantee my child a position on a team, but only permits them to try out.

_____________________________________ _____________________________________

Parent/Guardian Signature Date

NEWBURGH ENLARGED CITY SCHOOL DISTRICT – HEALTH SERVICES

INTERVAL HEALTH HISTORY *FOR SPORTS PARTICIPATION*

SCHOOL NAME: ____

All students participating in Sports must have a physical exam on file for the current school year. Prior to beginning each subsequent season, an Interval Health History must be completed.

PART A:

Student Name: _____________________________ D.O.B: ___/___/___ Age: _____ Grade: _____

ID # __________ Sport: _________________ Level: Varsity JV Modified

Date of last health appraisal: _____/_____/_____ Limitations: ______yes ______no

PART B: TO BE COMPLETED BY THE PARENT OR GUARDIAN

Note: "Yes" to any of these questions below does not mean automatic disqualification from the athletic activity indicated in PART A above. However, it will require a review and approval by the school physician before the student can report to practice or tryouts. The answers to the questions on this form will be held in the school health office and will be kept confidential.

HISTORY SINCE LAST HEALTH APPRAISAL:

If the answer to any of the following questions is "YES" - on the reverse side of this form in PART C, please describe the condition or situation that prompted your answer.

1. Any injuries requiring medical attention? _____ yes _____ no
2. Any illness lasting more than five (5) days? _____ yes _____ no
3. Taking medicine or under physician's care at this time? _____ yes _____ no
4. Any feeling of faintness, dizziness or fatigue after exercise or exertion? _____ yes _____ no
5. Change in wearing glasses or contact lenses? _____ yes _____ no
6. Any surgical operations or fractures? _____ yes _____ no
7. Any treatment in a hospital or emergency room? _____ yes _____ no
8. Developed any allergies? _____ yes _____ no
9. Any chronic disease? _____ yes _____ no

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PART C: TO BE COMPLETED BY PARENT OR GUARDIAN

Describe the condition or situation that caused any questions in PART B to be answered "YES".

____
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PART D: PARENTAL PERMISSION

To the best of my knowledge, this health interval is correct. I realize that there is a risk of being injured that is inherent in all sports. I realize the risk of injury may be severe, including the risk of fracture, brain injury, paralysis or even death.

Understanding the above, I give permission for my son/daughter _________________________________,
a student in the Newburgh Enlarged City School District to participate in: __________________________.
SPORT NAME

SIGNED: ____ DATE: ___________________
Parent/Guardian Signature

Address:____

Home/Cell phone number: ____

PLEASE RETURN TO THE SCHOOL HEALTH OFFICE

PART E: TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE

Sports Participation:

_________ Approved _________ Referred to School Physician

Signed: ______________________________________ Date: _____/_____/_____
School Health Office NP/SNT/RN Signature

If referred to the School Physician:

______ Requalified _________ Disqualified

Signed: ___________________________________ Date: _____/_____/_____
School Physician Signature

NEWBURGH ENLARGED CITY SCHOOL DISTRICT – HEALTH SERVICES

PREPARTICIPATION/ATHLETIC HEALTH HISTORY – Two Page Form

School Name: ____

Student Name: ______________________ DOB: ____/____/_____ I.D. # _______________

Grade (check): ❑ 7 ❑ 8 ❑ 9 ❑ 10 ❑ 11 ❑ 12 Gender: M___ F ___

Sport: ______________________ Level (check): ❑ Varsity ❑ JV ❑ Modified

Date of last health exam: _____/_____/_____ Limitations: ❑ Yes ❑ No Date form completed____/____/_____

Health History To Be Completed By Parent/Guardian

Answer questions below to indicate if your child has or has ever had the following and provide details to any yes answer on back:

Question	YES	NO
Has a doctor or nurse practitioner (a health care provider) ever restricted his/her participation in sports for any reason?		
Does s/he have an ongoing medical condition? Please check below: ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Other ☐ Sickle Cell trait or disease		
Has s/he ever had surgery?		
Has s/he ever spent the night in a hospital?		
Does s/he have a life threatening allergy? Please check below: ☐ Medication ☐ Food ☐ Insect bites ☐ Pollen ☐ Latex ☐ Other		
Does s/he carry an Epi-pen (epinephrine)?		
Has s/he ever passed out during or after exercise?		
Has s/he ever complained of light headedness or dizziness during or after exercise?		
Has s/he ever complained of chest pain, tightness or pressure during or after exercise?		
Has s/he ever complained of fluttering in their chest, skipped beats, or their heart racing, or does s/he have a pacemaker?		
Has a health care provider ever ordered a test for his/her heart? (ex. EKG, echocardiogram, stress test)		
Has s/he been told s/he has a heart condition or problem?		
Has s/he ever had high or low blood pressure?		
Has s/he ever complained of getting more tired or short of breath than his/her friends during exercise?		
Does s/he wheeze or cough frequently during or after exercise?		
Has a health care provider ever said s/he has asthma?		
Does s/he use or carry an inhaler or nebulizer?		
Has s/he ever become ill while exercising in hot weather?		
Is s/he on a special diet or have to avoid certain foods?		
Does s/he worry about their weight?		

Question	YES	NO
Does s/he have stomach problems?		
Has s/he ever had a hit to the head that caused a headache, dizziness, nausea, or confusion, or been told s/he had a concussion?		
Does s/he ever have headaches with exercise?		
Has s/he ever had a seizure?		
Is s/he currently being treated for a seizure disorder or epilepsy?		
Has s/he ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling?		
Has s/he ever an injury, pain, or swelling of joint that caused him/her to miss practice or a game?		
Does s/he use a brace, orthotic or other device?		
Does s/he have any problems with his/her hearing or wear hearing aids?		
Does s/he have any problems with his/her vision or have vision in one eye only?		
Does s/he wear glasses or contacts?		
Has s/he ever had a hernia?		
Does s/he have only 1 functioning kidney?		
Does s/he have a bleeding disorder?		
Females Only	**YES**	**NO**
Has she had her period? At what age did it begin? ___________		
How often does she get her period?		
Date of last menstrual period____________		
Males Only	**YES**	**NO**
Does he have only one testicle?		
Family History	**YES**	**NO**
Has any relative been diagnosed with a heart condition or developed hypertrophic cardiomyopathy, Marfan Syndrome, right ventricular cardiomyopathy, long QT or short QT syndrome, Brugada Syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
Has any relative died suddenly before the age of 50 from unknown or heart related cause?		

PREPARTICIPATION/ATHLETIC HEALTH HISTORY – Page 2

Student Name: ____ DOB: ____/____/_____

Please explain fully any question you answered yes to in the space below (Please print clearly, and provide dates if known):

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I certify that to the best of my knowledge my answers are complete and true. I realize that there is a risk of being injured that is inherent in all sports. I realize the risk of injury may be severe, including the risk of fracture, brain injury, paralysis or even death.

Understanding the above, I give permission for my son/daughter ____,
a student in the Newburgh Enlarged City School District to participate in ________________________________.
Name of Sport

DATE: ______________________ ____

PARENT/GUARDIAN SIGNATURE

ADDRESS: ____

HOME/CELL PHONE NUMBER: ____

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NEWBURGH ENLARGED CITY SCHOOL DISTRICT

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 received today:

☐ Immunizations reported on NYSIIS

☐ No immunizations received today ☐ Will return on: to receive:

HEALTH HISTORY

☐ **Asthma** ☐ Intermittent ☐ Persistent ☐ Asthma Action Plan Attached

☐ **Diabetes** ☐ Type 1 ☐ 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 ☐ Antihistamine ☐ Epinephrine Auto injector

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:

Weight Status Category (BMI Percentile): ___ ___.___

☐ < 5th ☐ 85th – 94th

☐ 5th – 49th ☐ 95th – 98th

☐ 50th – 84th ☐ 99th & higher

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			☐ **yes** ☐ **no**
Dental Referral			☐ yes ☐ no

Check development 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:

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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 auto injector, 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 document 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: **Phone #:** **Fax #:**