

Please return completed and signed forms to Cora Clark, RN, School Nurse

LAKE PLACID CENTRAL SCHOOL ATHLETIC HEALTH HISTORY

Prior to the start of tryout sessions or practice at the beginning of each season, a health history review for each athlete must be conducted unless the student received a full medical examination within 30 days of the start of the season.

Student: _____ Date of Birth: _____ Age: _____

Address: _____

Parent/Guardian Names: _____

Contact Numbers: _____

In an emergency contact: _____ Number(s) _____

Grade (check): 7 8 9 10 11 12 Date of Birth: ____/____/____

Sport: _____ Level (check): Varsity JV Frosh Jr. High

HEALTH HISTORY TO BE COMPLETED BY PARENT

Allergies (Bee Sting/Medications/Food/Latex,environmental.) Yes No

Does the student carry an Epi-pen[®] for a life-threatening allergy? Yes No

List allergies _____

Asthma Yes No

Does the student carry an inhaler? Yes No

Concussion/Head injury/Seizures/Headaches Yes No

Recent injury that requires medical attention or protective equipment? Yes No

Recent illness lasting longer than one week (ie. Mono) Yes No

Currently taking medications Yes No

Diabetes/Hypoglycemia Yes No

Heart/Blood Pressure Problems Yes No

Heat Exhaustion or Stroke Yes No

Hearing Impairment/Problems Yes No

Eye Problems/Vision Loss Yes No

Bleeding Tendency/Anemia Yes No

Recent Surgery or Hospitalization Yes No

Kidney/Liver Disease Yes No

Contact Lenses Yes No

Is there any medical condition that might be aggravated by playing sports? Yes No

Arthritis Yes No

Bladder/Kidney Problem or Injury Yes No

Injury to the Spleen Yes No

Joint Sprain/Ligament Tear/Muscle Pull Yes No

Elevated Blood Pressure Yes No

Heart Problem/Murmur-Chest pain Yes No

Nose Bleeds/Frequent or Severe Yes No

Back Pain/Injury Yes No

Fracture-Dislocation Bones/Joints Yes No

Neck Injury Yes No

Rheumatic Fever Yes No

Stomach Ulcer Yes No

	YES	NO
Is there a current medical examination on file in the nurse's office:	<input type="radio"/>	<input type="radio"/>
Is your child assigned to the Adaptive Physical Education Program or has he/she been in the Adaptive Physical Education?	<input type="radio"/>	<input type="radio"/>
Has your child been diagnosed with a concussion? Date _____	<input type="radio"/>	<input type="radio"/>
Does your child have any of the following:		
One eye or severe uncorrectable loss of vision in one or both eyes.....	<input type="radio"/>	<input type="radio"/>
Severe hearing loss in both ears.....	<input type="radio"/>	<input type="radio"/>
One kidney.....	<input type="radio"/>	<input type="radio"/>
One testicle.....	<input type="radio"/>	<input type="radio"/>
Has your child been ill for five (5) consecutive days?.....	<input type="radio"/>	<input type="radio"/>

Has your child ever had an illness, condition, or injury that required him/her to go to the hospital either as a patient overnight or in the emergency room or for x-rays; required an operation; caused your child to miss a game or practice? _____	<input type="radio"/>	<input type="radio"/>

Is your child under medical care now?.....	<input type="radio"/>	<input type="radio"/>
Has your child taken any medication in the past year?.....	<input type="radio"/>	<input type="radio"/>
Medications _____		

Has your child ever fainted?.....	<input type="radio"/>	<input type="radio"/>
If so, explain. _____		

Has there ever been sudden death in a family member under fifty (50) years of age?.....	<input type="radio"/>	<input type="radio"/>

Does your child have: orthodontic appliances?.....	<input type="radio"/>	<input type="radio"/>
Capped teeth?.....	<input type="radio"/>	<input type="radio"/>
Wear glasses for sports?.....	<input type="radio"/>	<input type="radio"/>
Since your child's last physical examination, has your child had any injury or illnesses?..	<input type="radio"/>	<input type="radio"/>

Describe the condition or situation that caused any questions to be answered "YES"

I agree with the above answers and consent to participation of my child in the interscholastic program of his/her school including practice sessions and travel to and from the athletic contests.

I clearly understand these questions are asked in order to decide if my child can safely participate on the athletic team on this form. I have read the concussion information sheet attached to this form and will keep the sheet for my records.

I also agree to emergency medical treatment as deemed necessary by the physicians designed by school authorities.

PARENT SIGNATURE: _____ **Date:** _____

TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE

Date of last health appraisal: ____/____/____

Limitations: Yes No

Sports Participation:

Approved Referred to School Physician

Signed: _____ Date: ____/____/____

FALL SPORT _____

ATHLETIC REGULATION SIGNATURE FORM

As an athlete at Lake Placid Central School, I have read the Athletic Regulation and understand the expectations and responsibilities that go along with being a member of a Lake Placid Central School athletic team.

_____ (Print Name)
Student

_____ (Sign Name)
Student

Dated: _____

I recognize my responsibility as a parent/guardian and having read the Athletic Regulation along with understanding that there is a risk of serious injury involved with participation in interscholastic sports, give my permission for my child to participate in athletics at Lake Placid Central School.

_____ (Print Name)
Parent/Guardian

_____ (Sign Name)
Parent/Guardian

Dated: _____