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:	o	o
Is your child assigned to the Adaptive Physical Education Program or has he/she been in the Adaptive Physical Education?	o	o
Has your child been diagnosed with a concussion? Date ________________	o	o
Does your child have any of the following:		
One eye or severe uncorrectable loss of vision in one or both eyes........................	o	o
Severe hearing loss in both ears..	o	o
One kidney..	o	o
One testicle..	o	o
Has your child been ill for five (5) consecutive days?...	o	o

____

	YES	NO
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?____________________	o	o

____

	YES	NO
Is your child under medical care now?..	o	o
Has your child taken any medication in the past year?......................................	o	o

Medications ____

____

	YES	NO
Has your child ever fainted?..	o	o

If so, explain.____

	YES	NO
Has there ever been sudden death in a family member under fifty (50) years of age?.......	o	o

____

	YES	NO
Does your child have: orthodontic appliances?..	o	o
Capped teeth?...	o	o
Wear glasses for sports?..	o	o
Since your child's last physical examination, has your child had any injury or illnesses?..	o	o

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: ____________________________________

Approved 9/2013