**SPACKENKILL UNION FREE SCHOOL DISTRICT**

**ATHLETIC PARTICIPATION FORM**

Coach’s Copy

\* PARENT and STUDENT Complete Side 1 & 2 and SIGN WHERE INDICATED

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade \_\_\_\_\_\_\_\_Sport \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (month/date/year)

|  |  |
| --- | --- |
| **Address:** | **Family Physician:** |
| **Parent/Guardian:** | **Physician’s Phone:** |
| **Home Phone:** | **Insurance Company:** |
| **Business Phone:** | **Insurance #:** |
| **Emergency Contact:** | **Preferred Hospital:** |
| **Emergency #:** |  |

**HEALTH INFORMATION FOR THE COACH**

Allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Does your child use an:  **EpiPen** \_\_\_\_\_ **Inhaler** \_\_\_\_\_

Asthma \_\_\_\_\_\_\_\_\_\_\_\_ Special braces or equipment needed for sports \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Conditions that the coach should be aware of for the safety of your child. (Please indicate)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**• Concussion Management:**

Spackenkill School District, in accordance with the Concussion Management and Awareness Act, will have its Medical Director evaluate any student who has sustained a concussion.  Upon receiving written clearance and signed authorization from the Medical Director a student may begin a graduated return to activities. District concussion policies and protocol can be found on the athletic website.

**• Medical Treatment Release:**

In case of an accident, I grant permission for necessary medical treatment to be obtained for my child if I cannot be reached.

**• Injury Requiring Transportation to a Hospital:**

In the event that my child sustains an injury that requires transportation to a hospital and I am not on-site, I give permission for another adult to accompany my child.

 **• Transportation Practices/Contest:**

I give permission for my son/daughter to take transportation provided by the district to off-site venues sanctioned by the District for practices/contests.

**• Athletic Program Consent to Release Information:**

The Spackenkill Athletic Program often receives sports coverage in the local press. In addition to reporting scores and player statistics, reporters often inquire as to the status of players who may have been injured during the course of a contest. The school district cannot release this information without the prior consent of a parent/guardian. Thus, I hereby consent to the release of information to the media should my child sustain an injury during his/her participation. This release of information will be limited to the general nature of my child’s injury and anticipated recovery time.

**• Student-Parent Athletic Handbook:**

By signing, the student athlete and parent/guardian indicate that they have read and understand the online version of the Student-Parent Athletic Handbook. I agree to fully support all of these conditions and give my daughter/son permission to try out for a Spackenkill School District team. If extended the privilege of making the team, I will follow the regulations in the Student-Parent Athletic Handbook and any additional training rules given to me by my coach. Athletic Handbook: [www.spackenkillschools.org/athletics/policies](http://www.spackenkillschools.org/athletics/policies)

**•** I fully understand that physical activity involves the potential for injury which, on rare occasions, can be severe and result in total disability, paralysis or even death.

 ***I consent to ALL of the above statements*.**

**Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_ Student’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL CERTIFICATION**

**Initial Physical must be done by the School Physician**

I certify that the above named student has had a physical examination and is approved to compete in sports during the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_year.

Date of physical \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Restrictions (if any) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of School Physician or School Nurse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



 Confidential – for Health Office Use Only

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_ Grade \_\_\_\_\_ Sport \_\_\_\_\_\_\_\_\_

 (month/date/year)

**Parent or Guardian, please complete and sign the health history below.**

|  |  |  |  |
| --- | --- | --- | --- |
| **DOES YOUR CHILD HAVE** | **No** | **Yes** | Explain “Yes” answers & give dates of Injury/Illness |

|  |  |  |  |
| --- | --- | --- | --- |
| A chronic illness |  |  |  |
| Any allergies |  |  |  |
| Asthma |  |  |  |
| Diabetes |  |  |  |
| Only one eye |  |  |  |
| Only one kidney |  |  |  |
| Seizure disorder/convulsions |  |  |  |
| Heart murmur/problem/chest pain |  |  |  |
| Hernia |  |  |  |
| False/capped teeth |  |  |  |
| Fainting problems |  |  |  |
| Back problem/back injury |  |  |  |
| Hip/knee/ankle problem or injuries |  |  |  |

**HAS YOUR CHILD**

|  |  |  |  |
| --- | --- | --- | --- |
| Had a doctor’s excuse for gym/sports in past 6 mos. |  |  |  |
| Been absent due to illness for a week or more |  |  |  |
| Had a concussion |  |  |  |
| Had a fracture (broken bone) |  |  |  |
| Had a dislocation |  |  |  |
| Been in the hospital overnight |  |  |  |
| Had a surgical operation |  |  |  |
| Ever had chest pain, syncope (fainting), or dizziness while exercising |  |  |  |

**DOES YOUR CHILD**

|  |  |  |  |
| --- | --- | --- | --- |
| Wear glasses/contact lenses for sports |  |  |  |
| Take medication daily |  |  |  |
| Use an EpiPen or Inhaler |  |  |  |
| Have a family history of anyone experiencing sudden cardiac death |  |  |  |
| **Males only**: Does your son have only one testicle? |  |  |  |
| **Females only:** Age menses began |  |  |  |
|  Are menses regular? |  |  |  |

I hereby state that to the best of my knowledge my answers to the above questions are complete and correct.

I understand that my child must have an initial examination by the school physician or associate for interscholastic sports. I understand that these questions are asked to determine if he/she is in proper condition to tryout/participate. “Yes” answers to any of these questions do not mean automatic disqualification from athletic activities.

|  |  |
| --- | --- |
| Signature ofParent/Guardian | Date: |