

**SWEET HOME CENTRAL SCHOOL DISTRICT
STUDENT ATHLETIC PARTICIPATION FORM**

Sports Hotline- 250-1256
Website- www.sweethomeschools.com

Christopher E. DeMarco
Director of Athletics
Phone-250-1207 Fax-250-1351

Dear Parent:

This participation form must be signed above and returned to the coach before the student will be permitted to participate in practice or competition.

PHYSICAL EXAM: New York State Interscholastic Sports Regulations require all athletes participating in a interscholastic athletic activity to have a physical exam before he/she may participate. This physical exam will be done in accordance with Sweet Home Central School District Policy.

PARENTAL CONSENT: My son/daughter _____ in grade ____ has my permission to participate in (name of sport) _____. I also give my permission for my child to participate in interscholastic contests, which may include overnight trips. I recognize that the element of risk cannot be eliminated, even when all precautions are taken. I realize that the school district does not carry any student accident insurance. Accordingly, I accept those risks and agree to all medical and hospital expenses which are not covered by my insurance. A volunteer program of student insurance cannot be offered by New York State public school systems. The coaching staff and other responsible school officials will do everything within reason to protect your child against injury.

Signature of Parent/Guardian _____ Date _____

With the knowledge that the school will take all ordinary precautions to avoid injury, but that it will not be held responsible or liable for any injuries that may be incurred during said season, I hereby grant:

(Name of student) _____ (Grade) _____ permission to participate in

(Name of sport) _____ at Sweet Home High School.

Signature of Parent _____ Date _____

PERMISSION FOR EMERGENCY MEDICAL TREATMENT: In the event of an emergency requiring medical attention every effort will be made to contact the parent/guardian in order to receive authorization before any treatment or hospitalization is undertaken. I hereby grant permission for the Athletic Trainer, Physician, or hospital personnel designated by the Sweet Home Central School District designee to attend to my son/daughter.

Signature of Parent/Guardian _____ Date _____

Home Phone _____ Work Phone _____ Mobile Phone/Pager _____

If parents or immediate family cannot be reached in an emergency the following individual shall be called.

Name _____ Relationship _____ Home Phone _____

INTERSCHOLASTIC ATHLETIC REGULATIONS: In order to participate in Interscholastic Athletics the student must:

1. Maintain standards as defined in the Athletic Regulations.
2. Abstain from the use of drugs, smoking, and alcoholic beverages.
3. Conform to any and all rules regarding safety and conditioning as defined by the coaches.
4. Shall be financially responsible for all supplies and equipment issued to him/her.
5. Be a good citizen at all times.

AN ATHLETE SHALL BE SUSPENDED FROM THE TEAM FOR VIOLATION OF ANY OF THE ABOVE REGULATIONS.

Signature of Parent/Guardian

Student Athlete Signature

Date

Name _____ Sex: M F Age _____ Date of Birth _____

Address _____ Grade _____ Sport _____

Health Insurance: yes no Insured by: _____ policy # _____

- head
- neck
- back
- chest
- shoulder
- upper arm
- Elbow
- forearm
- wrist
- hand
- finger
- hip
- thigh
- knee
- shin/calf
- ankle
- foot

All "yes" answers must be explained (box on bottom right)

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Have you had a medical illness or injury since your last check up or sports physical? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you been hospitalized overnight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you currently taking any prescription or nonprescription(OTC) medications or pills or using an inhaler? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any allergies(for example, pollen medicine, or stinging insects)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever been dizzy or passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had high blood sugar(diabetes)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever been diagnosed with anemia? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever had racing of your heart or skipped heartbeats? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you had high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever been told you have a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Has any family member or relative died of problems, or of sudden death before the age of 50 | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you had a severe viral infection (for example myocarditis or mononucleousis) within the last month? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Has a physician ever denied or restricted your participation in sports for any heart problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever been diagnosed with blood or bleeding disorders? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Do you have one kidney or one testicle? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you ever been knocked out, become unconscious, or lost your memory? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Have you ever had a seizure or convulsion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Do you have frequent or severe headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Have you ever had numbness or tingling in your arms, hand, legs, or feet from a stinger, burner or pinched nerve, or other condition? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Do you cough, wheeze, or have trouble breathing during or after activity? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Do you have asthma or lung disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Have you ever had any problem with your ears or hearing? | <input type="checkbox"/> | <input type="checkbox"/> |

29. Have you ever experienced abdominal pain?
30. Has there been any unexplained weight loss or weight gain during the past 6 mos.?
31. Are you currently following any particular diet or weight reducing plan?
32. Have you ever tried to control weight by vomiting, using laxatives, diuretics or diet pills?
33. Do you have a history of eating disorders?
34. Date of last tetanus shot _____

Females only

35. Has there been a recent change in menstrual patterns?
36. When was your most recent menstrual period ____/____/____

Explain 'Yes' Answers here (identify each Answer with question number)

- | | Yes | No |
|---|--------------------------|--------------------------|
| 26. Do you wear protective glasses or contacts ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Have you broken or fractured any bones, or dislocated any joints, or been diagnosed with a stress fracture? | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Have you ever had a sprain, strain or swelling after injury, or any other problems with pain or swelling in muscles, tendons bones, or joints that has kept you from participating in sports? | <input type="checkbox"/> | <input type="checkbox"/> |

If yes, check appropriate boxes and explain below:

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

Signature of athlete _____ Parent/Guardian _____ date _____