Valley Central School District
Athletic Participation Form

Student's Name: _____ Grade: _____ DOB: _____ Gender: _____
Address: _____ Home Phone: _____
Parent/ Guardian Name: _____ Cell Phone: _____ Work Phone: _____
Emergency Phone: _____ Relationship _____ **Mod.** ____ **Fresh.** ____ **JV**_____ **Varsity**___
Fall Sport:_____ **Winter Sport**:_____ **Spring Sport**:_____

Medical History	Y	N	Medical History	Y	N
Have you had a medical illness or injury since your last Check-up or sports physical?			Do you have seasonal allergies that require medical treatment?		
Have you ever been hospitalized overnight?			Do you use any special protective equipment or devices that aren't usually used for your sport or position?		
Are you currently taking any prescription or over the counter medications or using an inhaler?			Have you had any problems with your eyes or vision?		
Have you ever taken any vitamins or supplements to help you gain or lose weight or improve your performance?			Have you ever had a sprain, strain or swelling after an injury?		
Do you have any allergies to pollen, medicine, food or insects?			Have you broken any bones or dislocated any joints?		
Have you ever passed out during or after practice or when startled?			Have you had any problems with pain or swelling in muscles, tendons, bones or joints?		
Have you ever been dizzy during or after exercise?			*If yes, circle appropriate choice and explain below*		
Have you ever had chest pain/pressure during or after exercise?			Head Elbow Hip Neck Forearm Thigh Back		
Do you get tired more quickly than your friends do during exercise?			Back Wrist Knee Chest Hand Ankle Foot Shin/calf Shoulder Finger Upper Arm		
Have you ever had racing of your heart or skipped beats?			Do you have asthma?		
Have you had high blood pressure or high cholesterol?			Do you want to weigh more or less than you do now?		
Have you ever been told you have a heart murmur?			Do you feel stressed out?		
Has any family member or relative died of heart problems or sudden death before the age of 50?			Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?		
Has a doctor ever denied or restricted your participation in sports for any heart problem?			Do you have any skin problems (for example, itching, rashes, acne, warts, fungus or blisters?		
Have you become ill from exercising in the heat?			Have you ever had a head injury or concussion?		
Do you cough, wheeze or have trouble breathing during or after activity?			Have you ever been knocked out, or become unconscious or lost your memory?		
Have you ever had a seizure?			*Females Only*		
Have you ever had a stinger, burner or pinched nerve?			When was your first menstrual period?		
Have you ever had numbness or tingling in your arms, hands, legs or feet?			How much time do you usually have from the start of one period to the start of the next?		
Do you have frequent or severe headaches?			When was your most recent menstrual period?		
Do you wear glasses or contacts?			How many periods have you had in the last year?		
Do you have ear or hearing problems?			What was the longest time between periods in the last year?		

If you answered yes to any of the above questions please explain here:_____

If the student has a medical condition or a potential medical condition that may require medication; i.e. a life threatening allergy, diabetes etc. , it is required that an up-to-date Emergency Health Care plan, Physician orders and the required medication be on site prior to participation.

In case of an injury suffered by my child while participating in the above-stated sports/ activities, I give the coach and/or other school official in charge permission to obtain medical treatment for my child if I cannot be immediately contacted. Following treatment, the coach or other school official will notify me as soon as possible regarding the nature of the injury and any treatment rendered. I hereby acknowledge that I am familiar with the nature and risk of a concussion and head injury while participating in interscholastic athletics, including the risks associated with continuing to compete after a concussion or head injury. Information relevant to concussion in school sports is available on the CDC (Center for Disease Control) website at www.cdc.gov/concussion/index.html.

I hereby certify that all of the information is correct.

Parent/ Guardian signature: _____ Date: _____

Medical Certification

I have reviewed the data above and the cumulative health record and make the following recommendations for participation in athletics.

Physical Exam date:_____

___ Cleared without restrictions

___ Cleared with the following restriction(s): _____
___ Emergency Care Plan Obtained
___ Emergency Medication is on site: __ Inhaler, __ Epi-Pen, __Glucagon, __ Other: _____

School Nurse's signature:_____ Date signed: _____ Revised 9/15

PLEASE RETURN TO THE HEALTH OFFICE