

**ATHLETIC PARTICIPATION FORMS**

(Please: Do Not Remove Staple)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Phone \_\_\_\_\_

Street \_\_\_\_\_ Town \_\_\_\_\_ Zip \_\_\_\_\_

Male \_\_\_\_\_ Female \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

Welcome to the Lynbrook Public Schools Interscholastic Athletic Program. We are glad you have decided to participate and we wish you well in the upcoming season.

In order to insure proper safety and conduct, the following attached forms must be completed and submitted to the coach before an athlete can participate:

- Parent Permission Form for Athletic Participation (page 2)
- Lynbrook Public Schools Athletic Physical Form (page 3 Section I, page 4, Section III)
- Lynbrook Public Schools Athletic Contract (page 5)
- Interval Health History Form (page 6)

Please Note: An athlete must have had a physical examination by either a school doctor or family physician **within one calendar year** of the first day of practice. The exam **must** be submitted on the Lynbrook Public Schools Athletic Physical Form. An athlete who has submitted the Lynbrook Public Schools Athletic Form within the past calendar year need only hand in the Interval Health History form, which is to be completed by a parent/guardian. If Physical is older than 30 days from the start of the season an interval health history form must also be handed in.

Thank you for your cooperation. Please feel free to contact our District Athletic Nurse, (887-0228), any school day if you have any questions.

Sincerely,

Thomas Graham, Director  
Physical Education, Athletics and Health

***ENTIRE PACKET MUST BE COMPLETED & RETURNED TO THE ATHLETIC OFFICE  
PRIOR TO PARTICIPATION IN ANY PRACTICE OR CONTEST***

LYNBROOK PUBLIC SCHOOLS  
PARENT PERMISSION FORM  
FOR ATHLETIC PARTICIPATION  
\_\_\_\_\_ - \_\_\_\_\_ School Year

STUDENT INFORMATION:

Last \_\_\_\_\_ First \_\_\_\_\_ Birthdate \_\_\_\_\_

Grade \_\_\_\_\_ School \_\_\_\_\_ Sport \_\_\_\_\_

I RECOGNIZE THAT PARTICIPATION IN ALL SPORTS, ESPECIALLY THOSE INVOLVING CONTACT, REQUIRES AN ACCEPTANCE OF RISK OF POSSIBLE SERIOUS INJURY. THESE RISKS CANNOT BE ELIMINATED EVEN WHEN ALL PRECAUTIONS ARE TAKEN.

I ALSO UNDERSTAND THAT ALL STUDENTS ARE COVERED BY *PUPIL BENEFITS PLAN* INSURANCE WHICH, IN MOST CASES WILL NOT PAY ENTIRE MEDICAL COSTS AND SHOULD BE VIEWED AS A SUPPLEMENT TO MY OWN POLICY.

**I give my consent for my child \_\_\_\_\_ to participate in athletics for the \_\_\_\_\_ - \_\_\_\_\_ school year subject to a physical examination and or interval health history report.**

In the case of an emergency, if a parent cannot be reached, please contact the person(s) listed below who will assume temporary care of my child: If there are any changes during the school year it is the responsibility of the parent or guardian to contact the district nurse (887-0228) of the changes.

\_\_\_\_\_  
Name Phone # Relationship to Athlete

\_\_\_\_\_  
Name Phone # Relationship to Athlete

\_\_\_\_\_  
Name Phone # Relationship to Athlete

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**Physical/Athletic Examination Form (Only Lynbrook Public Schools Form Will Be Accepted)**

If you are a Grade 7-12 Student Athlete, you MUST complete Sections 1 and 3. If you are entering Grades K,2,4,7,10, or are a new entrant, the NYS Dept of Education requires physical examinations be conducted and Sections 1 and 2 MUST be completed and be submitted to the nurse's office in your home school. NYS Department of Education recommends dental examinations for all students annually. **Make extra copies of this form!**

**SECTION 1 (All Students Entering Grades K,2,4,7,10, New Entrants and All Grades 7-12 Student Athletes)**

Child's Last Name/First Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Parents'/Guardians' Name \_\_\_\_\_ Teacher \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_ Grade/ New Entrant \_\_\_\_\_

Ethnicity: ( ) Black (not Hispanic) ( ) White (not Hispanic) ( ) Hispanic ( ) Asian ( ) Other

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Physician's Information (Physicians MUST also sign on the bottom of the next page for Athletic Physicals!!!!)**

Physician's Name \_\_\_\_\_ Physician's Address \_\_\_\_\_ Physician's Phone Number \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date of Student Examination \_\_\_\_\_

**Examination**

Does this child require any medications (please specify)? \_\_\_\_\_

Does this child have any physical challenges (specify)? \_\_\_\_\_

Is this child physically able to participate in Physical Education? If NO, list restrictions: \_\_\_\_\_

Are there any problems relating to growth, development or nutrition with which teacher or nurse should be acquainted? \_\_\_\_\_

Food Allergies? \_\_\_\_\_

Height	Lungs	Nervous System	Speech
Weight	Abdomen	Thyroid	Nutrition
Blood Pressure	Hernia	Heart	Teeth/Gums
Eyes	Genitalia	Epilepsy	Posture
Ears	Skin	Orthopedic	Feet
Nose	Tonsils/Throat	Scoliosis	Range of Motion

**SECTION 2-Immunizations/Preventive Measures and Tests (All Students Entering Grade K,2,4,7,10 and New Entrants)**

Fill in Month/Date/Year	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>	Comments
DPT – DT Td Tdap					
Polio					
MMR					
Hib/HBCV					
Hepatitis B					
Varicella					
PPD					
Meningococcal					
Measles					
Mumps					
Rubella					
Other					

**Health History (Please fill in month and year below)**

Allergy	Epilepsy	Operations	Serious Injury
Asthma	German Measles	Pneumonia	Tonsillectomy
Chicken Pox	Heart Condition	Polio	Tuberculosis
Diabetes	Measles	Rheumatic Fever	T.B. Contacts
Ear Condition	Mumps	Scarlet Fever	Whooping Cough

Body Mass Index (BMI): \_\_\_\_\_  
Weight Status Category (sex-specific BMI- for age percentile):

In the last twelve months, has the student had:

- \_\_\_\_\_ < 5<sup>th</sup>
- \_\_\_\_\_ 5<sup>th</sup> to < 50<sup>th</sup>
- \_\_\_\_\_ 50<sup>th</sup> to < 85<sup>th</sup>
- \_\_\_\_\_ 85<sup>th</sup> to < 95<sup>th</sup>
- \_\_\_\_\_ 95<sup>th</sup> and over

- |                 |           |          |
|-----------------|-----------|----------|
| Prediabetes     | _____ Yes | _____ No |
| Type 1 diabetes | _____ Yes | _____ No |
| Type 2 diabetes | _____ Yes | _____ No |
| Asthma          | _____ Yes | _____ No |
| Prehypertension | _____ Yes | _____ No |
| Hypertension    | _____ Yes | _____ No |

**SECTION 3-ATHLETIC PHYSICAL FORM (All Grades 7-12 Student Athletes)**

**To The Student & Guardian:** Competitive athletics requires vigorous exercise and training. The District encourages all of its students to participate. To ascertain their health status, we require an annual sports-oriented evaluation. The questions below are to be completed by the guardian and the student and are to be signed by both.

THIS FORM MUST BE COMPLETED FOR ALL MIDDLE/ HIGH SCHOOL STUDENT ATHLETES AND DATED **WITHIN ONE CALENDAR YEAR OF YOUR LAST ATHLETIC PHYSICAL** BY YOUR PHYSICIAN OR THE SCHOOL PHYSICIAN. **PHYSICALS ATTACHED TO THIS FORM WILL NOT BE ACCEPTED.**

Female \_\_\_\_\_ Male \_\_\_\_\_ Sports (List all sports you plan to participate in) \_\_\_\_\_

**HAS THE STUDENT HAD ANY:**

- |     | YES   | NO    |
|-----|-------|-------|
| 1.  | _____ | _____ |
| 2.  | _____ | _____ |
| 3.  | _____ | _____ |
| 4.  | _____ | _____ |
| 5.  | _____ | _____ |
| 6.  | _____ | _____ |
| 7.  | _____ | _____ |
| 8.  | _____ | _____ |
| 9.  | _____ | _____ |
| 10. | _____ | _____ |
| 11. | _____ | _____ |
| 12. | _____ | _____ |

- Chronic/recurrent illness
- Illness lasting over one week
- Hospitalization
- Surgery (other than tonsillectomy)
- Missing organs (eye, kidney, testicle, etc)
- Allergy to any medications
- Problems with heart, blood pressure or murmur
- Chest pains with exercise
- Dizziness or fainting with exercise
- Dizziness, fainting, frequent headaches or convulsions
- Concussion or unconsciousness
- Heat exhaustion, heat stroke or other problems with heat

**DOES THE STUDENT:**

- |     |       |       |
|-----|-------|-------|
| 13. | _____ | _____ |
| 14. | _____ | _____ |
| 15. | _____ | _____ |
| 16. | _____ | _____ |

- Wear eyeglasses or contact lenses
- Wear dental bridges, braces, plates
- Take any medication (presently or recently)
- Wear any supports or braces

**IS THERE A HISTORY OF:**

- |     |       |       |
|-----|-------|-------|
| 17. | _____ | _____ |
| 18. | _____ | _____ |
| 19. | _____ | _____ |
| 20. | _____ | _____ |
| 21. | _____ | _____ |
| 22. | _____ | _____ |
| 23. | _____ | _____ |
| 24. | _____ | _____ |

- Injuries requiring MD Treatment
- Neck injury
- Knee injury or ankle injury
- Other serious joint injury
- Broken bones
- Is there any reason this student should not participate in athletics
- Has any family member, younger than 40 years of age, died suddenly due to an incident other than an accident
- Has any family member had a heart attack younger than 55 years of age

Explain any "Yes" response and provide additional information, if necessary:

\_\_\_\_\_

Date of Last Tetanus Shot: \_\_\_\_\_

We understand the statements above to be true and consent is hereby given that \_\_\_\_\_ may participate in interscholastic athletics.

Students Signature \_\_\_\_\_ Date \_\_\_\_\_ Parents Signature \_\_\_\_\_ Date \_\_\_\_\_

**This Section to be complete by Physician**

Review of Questionnaire \_\_\_\_\_ Positive Findings \_\_\_\_\_

1. Collision Contact \_\_\_\_\_ 2. Limited Contact \_\_\_\_\_ 3. Non-Contact \_\_\_\_\_

Based on this history and exam, the following abnormalities were found and need attention and treatment:

**Recommendations:**

1. \_\_\_\_\_ There is no history or physical finding which would prohibit this student from participating in athletics.
2. \_\_\_\_\_ This student should have the following health problems evaluated and/or treated before participating in athletics:
3. \_\_\_\_\_ This student has health problems which prohibits him/her from participation in athletics.

Signature of Physician \_\_\_\_\_ Date of Examination \_\_\_\_\_

**LYNBROOK PUBLIC SCHOOLS  
ATHLETIC PARTICIPATION CONTRACT  
\_\_\_\_\_ – \_\_\_\_\_ School Year**

**PRIOR TO PARTICIPATION:**

- 1. Athletes will successfully pass a physical examination. The school physician will provide this exam on a specified date prior to the season **OR** the athlete may go to his/her personal physician. In either case, the appropriate **LYNBROOK MEDICAL FORM** must be on file. Notes on physician’s letterhead are **NOT** acceptable.
- 2. Parent Permission Form with emergency information must be returned to the coach. Parents should pay particular attention to the statement on the Permission Form regarding possible risk of serious injury.

**REGULATIONS:**

- 1. The school is not responsible for personal property. At no time should valuables be left in the locker room.
- 2. All injuries sustained during participation must be reported immediately to the coach in order that the appropriate insurance forms can be filed. Parents should understand that the school district’s insurance policy is a supplementary policy to their coverage and only partially covers what is not covered under the family’s policy. Any athlete requiring medical attention by a physician must have a physician’s note to resume activity.
- 3. All equipment issued must be maintained in good condition and returned at the conclusion of the season. Equipment not returned must be paid for at the **current replacement cost**. An athlete may not join a subsequent team until these obligations are satisfied. Additionally, report cards and/or diplomas will be withheld.
- 4. Attendance at all practices and games as scheduled by the coach are mandatory. It is the athlete’s responsibility to notify the coach if it becomes necessary to miss a practice or game.
- 5. Athletes must be signed into school by 8:00 am and attend all classes in order to practice or play. Any student signing in late because of legal or medical appointments must have an approval note from the Athletic Director prior to practice.
- 6. Academic Standards: In order to remain eligible for participation in athletics, district students must not fail more than two subjects during a given marking period. Any athlete failing two or more subjects will be placed on academic probation by the district. Failing to seek improvement in one’s academic standing during this probation period will result in loss of eligibility.
- 7. There is a responsibility both on and off the playing fields/courts to behave in a manner that reflects favorably on the team and the Lynbrook Public Schools. Actions that are not acceptable and subject to disciplinary action included but are not limited to fighting, vandalism or any acts of unsportsmanlike.
- 8. **THE USE OF TOBACCO, ALCOHOL OR OTHER DRUGS WILL BE GROUNDS FOR DISCIPLINARY ACTION/SUSPENSION FROM THE TEAM.**

I grant my permission, authority and consent to the Lynbrook Union Free School District, and Section VIII of the New York State Public High School Athletic Association (“Section VIII”) to broadcast the image and voice of my son/daughter, on any other media outlet, including but not limited to television and radio stations, online/internet websites and any other media outlet of the District or Section VIII’s choosing during any and all contests, games and other competition on the Lynbrook School District’s Athletic team.

I HAVE READ, UNDERSTAND AND WILL ABIDE BY THIS AGREEMENT:

Student Signature \_\_\_\_\_ Date \_\_\_\_\_  
Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

**INTERVAL HEALTH HISTORY FOR SPORTS PARTICIPATION**

Prior to the start of the sports season, this health history review MUST be completed UNLESS the student has had a full medical exam within 30 days of the START of the season.

Name \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sport \_\_\_\_\_ Level \_\_\_\_\_

**PART A – TO BE COMPLETED BY PARENT/GUARDIAN:**

**HEALTH HISTORY SINCE LAST PHYSICAL EXAM:**

If the answer to any of the following questions is “YES”, please describe the condition that prompted your answer in Part B on the reverse side of this form:

	<b><u>CHECK ONE</u></b>	<b><u>YES</u></b>	<b><u>NO</u></b>
1.	Any injuries requiring medical attention?	_____	_____
2.	Any illness lasting more than 5 days?	_____	_____
3.	Taking medicine or under doctor’s care at this time?	_____	_____
4.	Any dizziness, faintness or fatigue after exercise or exertion?	_____	_____
5.	Change in wearing glasses or contact lenses?	_____	_____
6.	Any surgical operations or fractures?	_____	_____
7.	Any treatment in a hospital or emergency room?	_____	_____
8.	Developed any allergies?	_____	_____

**PART B – TO BE COMPLETED BY PARENT OR GUARDIAN:**

Describe below the condition or situation that caused any question in PART B to be answered “YES”:

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**PART C – PARENT/GUARDIAN PERMISSION:**

I, the undersigned, clearly understand these questions are asked in order to determine if my child can safely participate on the athletic team named in PART A of this form. The answers are correct as of this date and he/she has my permission to participate:

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**For Official School Use Only** - School Nurse/Doctor Signature \_\_\_\_\_ Date \_\_\_\_\_