



High School
30 Johnson St
Lackawanna, New York 14218
Phone: (716) 939-2554
Fax: (716) 381-9901

Elementary Middle School
1001 Ridge Road
Lackawanna, New York 14218
Phone: (716) 821-1903
Fax: (716) 821-9563

Dear Parents and Guardians,

Your son/daughter expressed interest in joining a Global Concepts Charter School Varsity Sports team. Varsity and Junior Varsity (high school) tryouts and practice are scheduled to begin on or shortly after Monday November 13, 2023.

The date, time and location of sports tryouts and practices will be posted on the Global Concepts website Athletics page – www.globalccs.org – please check for updates.

STUDENTS WHO WISH TO PARTICPATE IN A FALL SPORT ARE TO RETURN THE COMPLETED ATTACHED FORMS BY **MONDAY November 6** to the School Nurse at the **High School.**

By signing below, I give my child permission to participate in the below circled sport program at Global Concept Charter High School. I understand that the practices will take place after school and will pick up my child **on time** following practice or games. TO TRYOUT: your child **must** have a current physical (**within a year of 11/15/2023**) to participate. If you have any questions please contact Mr. Klein at 939-2554 or jklein@globalccs.org

My child is interested in participating in the following sport **(Circle 1):**

Girls' Basketball – Boys J. V. Basketball – Boys Varsity Basketball – High School Cheer Team

Student Name Print

Student Name Signature

Parent/Guardian Name Print

Parent/Guardian Signature

Current Homeroom Teacher and Grade _____

Global Concepts Charter School
Athlete Health and
Permission Release Form

1. I give permission for my son/daughter (print full name) _____ to participate on the (level/sport) _____ team for the 2023-2024 school year.
2. I understand that practices and meets will take place on and off of school property and in the community.
3. I understand that Global Concepts Charter School does not provide student accident insurance for participants in interscholastic athletics and that it is the responsibility for the parent/guardian to assume any costs through their insurance carrier.
4. I understand that participation in athletics may cause personal injury; including but **NOT** limited to sprains, strains, broken bones, cuts, wounds, scrapes, head, neck and back injuries.
5. I understand that I am financially responsible for any injuries to my son/daughter as stated in this release. I also agree to hold harmless Global Concepts Charter School and its employees and or its Board of Trustees for any such injury to my child.
6. I give permission for emergency transportation and or emergency treatment in the event of an injury incurred in connection with the athletics as stated above.

Medical Provider _____

Parent/Guardian Signature _____

Students Signature _____

Phone Number _____

Emergency Phone Number _____

Hospital Preference _____

GLOBAL CONCEPTS CHARTER SCHOOL
DISCLOSURE OF PROTECTED HEALTH INFORMATION

This form allows the providers designated below to share medical information concerning your child with the school district. This information will be used to allow healthcare collaboration to maintain student safety, provide care, or create/modify programming. Please sign and date this form and make sure the school nurse has a copy.

Student Name: _____ **Date of Birth:** _____

I hereby authorize the healthcare provider(s) listed below to share information of my child with the District Physician, School Nurse, Occupational Therapist (OT), Physical Therapist (PT), School Counselor, or School Psychologist:

Name of healthcare provider: _____ **Phone:** _____

Name of healthcare provider: _____ **Phone:** _____

Name of healthcare provider: _____ **Phone:** _____

Disclosure of requested health information shall be limited to the following (*please check one*):

☐ **All minimum necessary health information; OR**

☐ **Disease-specific information as described:** _____

****I UNDERSTAND THAT THIS AUTHORIZATION SHALL EXPIRE ON MY CHILD'S LAST DAY OF ENROLLMENT AT GLOBAL CONCEPTS CHARTER SCHOOL****

****I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME BY SENDING WRITTEN NOTIFICATION TO THE HEALTHCARE PROVIDERS' OFFICE AND TO THE DISTRICT ADMINISTRATIVE BUILDING****

****I UNDERSTAND THAT THE REVOCATION OF THIS AUTHORIZATION IS NOT EFFECTIVE IF THE HEALTHCARE PROVIDER HAS USED THE AUTHORIZATION BEFORE RECEIVING MY WRITTEN NOTICE****

****I UNDERSTAND THAT ANY PROTECTED HEALTH INFORMATION DISCLOSED AS A RESULT OF THIS AUTHORIZATION TO ANYONE NOT COVERED BY THE STATE AND FEDERAL PRIVACY LAWS AND REGULATIONS MAY BE SUBJECT TO RE-DISCLOSURE AND MAY NO LONGER BE PROTECTED BY FEDERAL AND STATE LAW****

****I UNDERSTAND THAT MY CHILD'S TREATMENT IS NOT DEPENDENT ON MY AGREEMENT TO RELEASE OR WITHHOLD INFORMATION****

Parent/Guardian Signature

Date

Relationship

Sample Recommended NYSED Interval Health History for Athletics--Two Page Form
Both pages must be completed.

Student Name:		DOB:	
School Name:		Age:	
Grade (check): <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12		Level (check): <input type="checkbox"/> Modified <input type="checkbox"/> Fresh <input type="checkbox"/> JV <input type="checkbox"/> Varsity	
Sport:		Limitations: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of last health exam:		Date form completed:	

Health History to Be Completed by Parent/Guardian, Provide Details to Any Yes Answers on Back.
Medicines needed at practice and/or athletic event require the proper paperwork, contact school with questions.

Has/Does your child:		
General Health Concerns	No	Yes
1. Ever been restricted by a health care provider from sports participation for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have an ongoing medical condition? <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Seizures <input type="checkbox"/> Sickle Cell trait or disease <input type="checkbox"/> Other		
3. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>
5. Been diagnosed with Mononucleosis within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have only one functioning kidney?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have a bleeding disorder?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have any problems with his/her hearing or wears hearing aid(s)?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have any problems with his/her vision or has vision in only one eye?	<input type="checkbox"/>	<input type="checkbox"/>
10. Wear glasses or contacts?	<input type="checkbox"/>	<input type="checkbox"/>
Allergies		
11. Have a life-threatening allergy? Check any that apply: <input type="checkbox"/> Food <input type="checkbox"/> Insect Bite <input type="checkbox"/> Latex <input type="checkbox"/> Medicine <input type="checkbox"/> Pollen <input type="checkbox"/> Other		
12. Carry an epinephrine auto-injector?		
Breathing (Respiratory) Health	No	Yes
13. Ever complained of getting more tired or short of breath than his/her friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
14. Wheeze or cough frequently during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
15. Ever been told by a health care provider they have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
16. Use or carry an inhaler or nebulizer?	<input type="checkbox"/>	<input type="checkbox"/>

Has/Does your child:		
Concussion/ Head Injury History	No	Yes
17. Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told he/she had a concussion?	<input type="checkbox"/>	<input type="checkbox"/>
18. Ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
19. Ever had headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
20. Ever had any unexplained seizures?	<input type="checkbox"/>	<input type="checkbox"/>
21. Currently receive treatment for a seizure disorder or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>
Devices/Accommodations	No	Yes
22. Use a brace, orthotic, or other device?	<input type="checkbox"/>	<input type="checkbox"/>
23. Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)? If yes, there may be need for another required form to be filled out.	<input type="checkbox"/>	<input type="checkbox"/>
24. Wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
Family History	No	Yes
25. Have any relative who's been diagnosed with a heart condition, such as a murmur, developed hypertrophic cardiomyopathy, Marfan Syndrome, Brugada Syndrome, right ventricular cardiomyopathy, long QT or short QT syndrome, or catecholaminergic polymorphic ventricular tachycardia?	<input type="checkbox"/>	<input type="checkbox"/>
Females Only	No	Yes
26. Begun having her period?	<input type="checkbox"/>	<input type="checkbox"/>
27. Age periods began:		
28. Have regular periods?	<input type="checkbox"/>	<input type="checkbox"/>
29. Date of last menstrual period:		
Males Only	No	Yes
30. Have only one testicle?	<input type="checkbox"/>	<input type="checkbox"/>
31. Have groin pain or a bulge or hernia in the groin?	<input type="checkbox"/>	<input type="checkbox"/>

Sample Recommended NYSED Interval Health History for Athletics -- Page 2

Student Name: _____

School Name: _____

DOB: _____

Has/Does your child:

Heart Health	No	Yes
32. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
33. Ever complained of light headedness or dizziness during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
34. Ever complained of chest pain, tightness or pressure during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
35. Ever complained of fluttering in their chest, skipped beats, or their heart racing, or does he/she have a pacemaker?	<input type="checkbox"/>	<input type="checkbox"/>
36. Ever had a test by a health care provider for his/her heart (e.g. EKG, echocardiogram stress test)?	<input type="checkbox"/>	<input type="checkbox"/>
37. Ever been told they have a heart condition or problem by a health care provider? If so, check all that apply: <input type="checkbox"/> Heart Infection <input type="checkbox"/> Heart Murmur <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Kawasaki Disease <input type="checkbox"/> Other: _____		
Injury History	No	Yes
38. Ever been diagnosed with a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>

Has/Does your child:

Injury History continued	No	Yes
39. Ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
40. Ever had an injury, pain, or swelling of joint that caused him/her to miss practice or a game?	<input type="checkbox"/>	<input type="checkbox"/>
41. Have a bone, muscle, or joint injury that bothers him/her?	<input type="checkbox"/>	<input type="checkbox"/>
42. Have joints become painful, swollen, warm, or red with use?	<input type="checkbox"/>	<input type="checkbox"/>
Skin Health	No	Yes
43. Currently have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
44. Have had a herpes or MRSA skin infections?	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Health	No	Yes
45. Ever become ill while exercising in hot weather?	<input type="checkbox"/>	<input type="checkbox"/>
46. Have a special diet or need to avoid certain foods?	<input type="checkbox"/>	<input type="checkbox"/>
47. Have to worry about his/her weight?	<input type="checkbox"/>	<input type="checkbox"/>
48. Have stomach problems?	<input type="checkbox"/>	<input type="checkbox"/>
49. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>

COVID-19 Information

	No	Yes
50. Has your child ever tested positive for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
51. Was your child symptomatic?	<input type="checkbox"/>	<input type="checkbox"/>
52. Did your child see a healthcare provider (HCP) for their COVID-19 symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
53. Did your child have any cardiac symptoms (new fast or slow heart rate, chest tightness or pain, blood pressure changes, or HCP diagnosed cardiac condition)? If yes, please provide additional information.	<input type="checkbox"/>	<input type="checkbox"/>
54. Was your child hospitalized? If yes, provide date(s)?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, was your child diagnosed with Multisystem Inflammatory syndrome (MISC)?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, is your child under a HCP's care for this?	<input type="checkbox"/>	<input type="checkbox"/>

Please explain fully any question you answered yes to in the space below, include dates if known. Use additional pages if necessary.

Parent/Guardian Signature: _____

Date: _____