GLOBAL CONCEPTS CHARTER SCHOOL

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 Fall sports team. Varsity (high school) and Modified (middle school) tryouts and practice are begin Monday August 19, 2019.

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 FRIDAY JUNE 14, 2019 to NURSE NICHOLE (**Elementary**) or NURSE NANCY (**High School**)

By signing below, I give my child permission to participate in the below circled sports program at Global Concept Charter Elementary School and/or 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) to participate. If you have any questions please contact Mr. Klein at 939-2554 of jklein@globalccs.org

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

7/8 Grade Modified Soccer – Varsity Volleyball – Varsity Soccer – Varsity Cross Country

_____ _____

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 child's full name) _____ to participate on the (level/sport)_____ team for the 2018-2019 school year.
2. I understand that practices and games may take place on and off Global Concepts Charter School property.
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 name _____

Parent/Guardian Signature_____Date_____

Students Signature_____

Students date of birth / grade / sex _____/_____/_____

Phone Number_____

Emergency Contact and Phone Number_____

Hospital Preference_____

APPENDIX B *Sample Recommended Form*

PREPARTICIPATION/INTERVAL ATHLETIC HEALTH HISTORY – Two Page Form

School Name: _____

Student Name: _____ DOB: ___/___/____

Grade (check): ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

Sport: _____ Level (check): ☐ Varsity ☐ JV ☐ Frosh ☐ Jr. High

Date of last health exam: ____/____/____Limitations: ☐ Yes ☐ No Date form completed___/___/____

Health History To Be Completed By Parent/Guardian

Answer questions below to indicate if your child has or has ever had the following.
Provide details to any yes answer on back:

	YES	NO
Ever been restricted by a doctor or nurse practitioner from sports participation for any reason?		
Have an ongoing medical condition? Please check below: ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Other ☐ Sickle Cell trait or disease		
Ever had surgery?		
Ever spent the night in a hospital?		
Have a life threatening allergy? ☐ Medication ☐ Food ☐ Insect bites ☐ Pollen ☐ Latex ☐ Other		
Carry an epinephrine auto-injector)?		
Ever passed out during or after exercise?		
Ever complained of light headedness or dizziness during or after exercise?		
Ever complained of chest pain, tightness or pressure during or after exercise?		
Ever complained of fluttering in their chest, skipped beats, or their heart racing, or does s/he have a pacemaker?		
Has a health care provider ever has a test by their physician for his/her heart? (eg. EKG, echocardiogram, stress test)		
Ever been told they have a heart condition or problem?		
Ever had high or low blood pressure?		
Ever complained of getting more tired or short of breath than his/her friends during exercise?		
Wheeze or cough frequently during or after exercise?		
Ever been told by their health care provider they have asthma?		
Use or carry an inhaler or nebulizer?		
Ever become ill while exercising in hot weather?		
On a special diet or have to avoid certain foods?		
Have to worry about their weight?		

	YES	NO
Have stomach problems?		
Ever had a hit to the head that caused a headache, dizziness, nausea, or confusion, or been told s/he had a concussion?		
Ever have headaches with exercise?		
Ever had a seizure?		
Currently being treated for a seizure disorder or epilepsy?		
Ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling?		
Ever an injury, pain, or swelling of joint that caused him/her to miss practice or a game?		
Use a brace, orthotic or other device?		
Have any problems with his/her hearing or wear hearing aids?		
Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)?		
Have any problems with his/her vision or have vision in one eye only?		
Wear glasses or contacts?		
Ever had a hernia?		
Does s/he have only 1 functioning kidney?		
Does s/he have a bleeding disorder?		
Females Only	**YES**	**NO**
Has she had her period? At what age did it begin?		
How often does she get her period?		
Date of last menstrual period		
Males Only	**YES**	**NO**
Does he have only one testicle?		
Family History	**YES**	**NO**
Has any relative been diagnosed with a heart condition or developed hypertrophic cardiomyopathy, Marfan Syndrome, right ventricular cardiomyopathy, long QT or short QT syndrome, Brugada Syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
Has any relative died suddenly before the age of 50 from unknown or heart related cause?		

PREPARTICIPATION/INTERVAL ATHLETIC HEALTH HISTORY – Page 2

School Name: ____

Student Name: ____________________________________ DOB: ___/___/____

Please explain fully any question you answered yes to in the space below (Please print clearly, and provide dates if known):

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I certify that to the best of my knowledge my answers are complete and true.

Parent/Guardian Signature: ________________________________ **Date:** ________

Reviewed by (Name and Title): ________________________________ **Date:** ________

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION

Name:	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type — ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No ☐ Yes, indicate type — ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No ☐ Yes, indicate type — ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No ☐ Yes, indicate type — ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ Type 1 ☐ Type 2 ☐ HbA1c results: _____ Date Drawn: _____

Risk Factors for Diabetes or Pre-Diabetes:
Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother; and/or pre-diabetes.

BMI_____kg/m2 **Percentile (Weight Status Category):** ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and>

Hyperlipidemia: ☐ No ☐ Yes **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

TESTS	Positive	Negative	Date
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL			

Other Pertinent Medical Concerns
One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
☐ Concussion – Last Occurrence: _____
☐ Mental Health: _____
☐ Other:

☐ **System Review and Exam Entirely Normal**

Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code

Name:				DOB:
SCREENINGS				
Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right** dB	**Left** dB	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No	
Deviation Degree:		Trunk Rotation Angle:		

Recommendations:

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications

- ☐ **No Contact Sports** **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling
- ☐ **No Non-Contact Sports** **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field
- ☐ **Other Restrictions:**

☐ **Developmental Stage for Athletic Placement Process ONLY**

Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports

Student is at **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Accommodations:** Use additional space below to explain

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ Other:

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: _____

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School attached**

List medications taken at home:		

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature:	**Date:**
Provider Name: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

Please Return This Form To Your Child's School When Entirely Completed.