



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 Spring sports team. Varsity (high school) and Modified tryouts and practice are scheduled to begin Monday March 4, 2019.

The date, time and location of all 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 SPRING SPORT ARE TO RETURN THE COMPLETED ATTACHED FORMS BY THURSDAY FEBRUARY 28, 2019 to NURSE GOODMAN-HOELSCHER (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 Track – Varsity Girls Softball – Varsity Track

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 _____

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: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Food <input type="checkbox"/> Insects <input type="checkbox"/> Latex <input type="checkbox"/> Medication	<input type="checkbox"/> Environmental

Asthma <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : _____	

Seizures <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Type: _____	Date of last seizure: _____

Diabetes <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> 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		<input type="checkbox"/>	<input type="checkbox"/>	
Sickle Cell Screen/PRN		<input type="checkbox"/>	<input type="checkbox"/>	
Lead Level Required, Grades Pre-K & K		Date		
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated > 10 µg/dL		<input type="checkbox"/> Other: _____		

System Review and Exam Entirely Normal

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

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Neck	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code
	_____	_____
	_____	_____
	_____	_____

Additional Information Attached

Name: _____ DOB: _____

SCREENINGS

Vision	Right	Left	Referral	Notes
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail				
Hearing	Right dB	Left dB	Referral	
Pure Tone Screening			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Scoliosis	Negative	Positive	Referral	
Required for boys grade 9 And girls grades 5 & 7	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> 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
- | | | |
|---|---|---|
| <input type="checkbox"/> Brace*/Orthotic | <input type="checkbox"/> Colostomy Appliance* | <input type="checkbox"/> Hearing Aids |
| <input type="checkbox"/> Insulin Pump/Insulin Sensor* | <input type="checkbox"/> Medical/Prosthetic Device* | <input type="checkbox"/> Pacemaker/Defibrillator* |
| <input type="checkbox"/> Protective Equipment | <input type="checkbox"/> Sport Safety Goggles | <input type="checkbox"/> 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.

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: <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Seizures <input type="checkbox"/> Other <input type="checkbox"/> Sickle Cell trait or disease		
Ever had surgery?		
Ever spent the night in a hospital?		
Have a life threatening allergy? <input type="checkbox"/> Medication <input type="checkbox"/> Food <input type="checkbox"/> Insect bites <input type="checkbox"/> Pollen <input type="checkbox"/> Latex <input type="checkbox"/> 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?		

