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. Middle School tryouts and practice are begin Monday March 11, 2024.

Details of the exact date, time and location of all sports tryouts will be posted on the Global Concepts website spring sports Athletics page – www.globalconceptscs.org under Spring Sports.

STUDENTS WHO WISH TO PARTICPATE IN A SPRING SPORT ARE TO RETURN THE COMPLETED ATTACHED FORMS BY **MARCH 1, 2024** to the MIDDLE SCHOOL BUILDING NURSE.

By signing below, I give my child permission to participate in the below circled sports 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 the season start date), complete the attached documents, and **all proof of residency forms on file**. 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 Sport(s) of Interest):**

7/8 Grade Track and Field – 8th Grade Club Bowling - Club Softball

____________________________ 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 DOSCLOSED 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

Global Concepts Pre-Participation/Interval Sports Health History

PREPARTICIPATION/INTERVAL ATHLETIC HEALTH HISTORY – Two Page Form

School Name: Global Concepts Charter School

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: Global Concepts Charter School

Student Name: ____________________ DOB: ___/___/____

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

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:** ________