

NIAGARA WHEATFIELD CENTRAL SCHOOL DISTRICT
Part C- Parent Card/Interim Health History for Athletics & Parent Permission

Picked Up: _____
Returned: _____

I hereby permit _____ to play _____
 (Student Name/Age) (School/Grade) (Sport)
 during the _____ school year and give my consent for my child to accompany the team, as a member, on its out-of-town trips. In the event of an emergency requiring medical attention, I hereby grant permission for a physician or hospital personnel designated by the Niagara Wheatfield Central School District designee to attend to my son/daughter if I am unable to be contacted.

THIS CARD MUST BE TURNED IN TO THE HEALTH OFFICE.

I hereby state that to the best of my knowledge, the answers given below are correct and that there is no condition which would restrict participation in sports.

_____	_____	_____
(Date)	(Signature of Parent)	(Printed Name)
_____	_____	_____
(Date)	(Signature of Athlete)	(Printed Name)

SPORTS CANDIDATES QUESTIONNAIRE
HISTORY WITHIN LAST 12 MONTHS

- Have you missed more than 3 consecutive days of participation in usual activities because of injury this **past year**? Yes _____ **DATE** _____ No _____
 If yes: a) Describe injury _____
 b) Were you seen by a MD for this? Yes _____ No _____ Date _____
 c) Is written clearance for sports on file in nurse's office? Yes _____ No _____
- Have you missed more than 5 consecutive days of participation in usual activities because of an illness, or have you had a medical illness diagnosed that has not resolved in this **past year**?
 Yes _____ Illness: _____ Date(s) _____ No _____
- Have you had a seizure, concussion or been unconscious for any reason in the **last year**?
 Yes _____ **DATE** _____ No _____
- Have you had surgery or been hospitalized in this **past year**? Yes _____ No _____ **DATE** _____
 If yes: a) Reason for hospitalization _____
 b) Type of surgery _____
 c) Treating physician _____
 d) Is written clearance for sports on file in nurse's office? Yes _____ No _____
- Are you **presently taking** medication? Yes _____ No _____
 If yes: List all medications and what condition the medication is for:
 a) _____
 b) _____
- Last Menstrual Period: _____ N/A

TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE:

BP: _____ P: _____ TANNER I II III IV V N/A

Are you currently excused from gym/swim for any reason? (Please circle)

GYM: Yes No Reason: _____

SWIM: Yes No N/A Reason: _____

Sports Participation (Check): _____ Approved _____ Disqualified _____ Referred to PMD
 _____ Medical note on file Date _____ Physician _____

Signed: _____
 School Nurse/School Nurse Practitioner/Physician

Date: _____

PARENT MUST COMPLETE PAGE 2

**PARENT CARD – Coach’s Copy
HEALTH HISTORY**

Student Name: _____ Date of Birth: _____

Student Address: _____

School: _____ Grade: _____ SPORT: _____

Family Physician: _____ Phone: _____

Preferred Hospital: _____

List known allergies: _____

List Medications: _____

Additional medical information: _____

NOTE: PARENTS OF STUDENTS WITH ASTHMA, SEVERE ALLERGIES, DIABETES OR OTHER HEALTH CONDITIONS REQUIRING MEDICATION MUST SUPPLY THE APPROPRIATE MEDICATION(S) TO THE COACH TO CARRY. STUDENTS WILL NOT BE CLEARED FOR PLAY IF MEDICATION IS NOT SUPPLIED

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PERMISSION FOR EMERGENCY MEDICAL TREATMENT

The following information MUST be completed:

Mother’s name: _____ (H) _____ (W) _____
(Cell) _____

Father’s name: _____ (H) _____ (W) _____
(Cell) _____

Emergency Contact: #1 _____ (H) _____ (W) _____

Emergency Contact: #2 _____ (H) _____ (W) _____

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Parent signature authorizing permission for medical treatment is on file in the health office

Nurses Signature: _____ Date: _____

COACHES WILL KEEP THIS PAGE ON FILE AT ALL PRACTICES AND GAMES