Cincinnatus Central School District
Interscholastic Athletic Program Participation Form
Health Office – Phone (607) 863-3200 Fax (607) 863-3546

Name:_____Date of Birth:_____Grade:_____
Last First M.I. m/d/y

Address:_____
Street Town/City State Zip Code

I, _____, give my consent for _____ to
(Parent or Guardian – Please Print) (Student - Please Print)

participate in _____ subject to approval by the school nurse.
(Sport)

EMERGENCY INFORMATION

Contact #1:	Relationship:
Contact #1 Home Phone:	Contact #1 Cell Phone:
Contact #2:	Relationship:
Contact #2 Home Phone:	Contact #2 Cell Phone:
IF I CANNOT BE REACHED PLEASE CONTACT THE EMERGENCY CONTACT BELOW	
Emergency Contact:	Relationship:
Emergency Contact Home Phone:	Emergency Contact Cell Phone:
MEDICAL INFORMATION	
Family Physician:	Phone:
If possible, I would prefer that my child be taken to the following Hospital:	

NOTE: Parents are hereby advised athletics can be hazardous to the health of their children. Baseline testing for concussion management will be performed by the school nurse prior to contact for covered sports. **The student, parent or guardian is responsible for notifying the team coach AND School Nurse should and injury occur.**

Date of last Health Exam: _____ (If exam was more than 30 days ago, back of this form MUST be competed)

Since the last health exam, has your child had **any** injuries, fractures, major illnesses, or operation? **If none, indicate by writing NONE.** If yes, please specify: _____
****If any of the above occurred, include a doctor's release for your child to participate. A review and approval by the school Medical Director may also be required.**

ATHLETES MEDICAL ALERTS

Health/Medical Condition(s): _____

Allergies: _____

List any medications needed during the athletic event including rescue medications (i.e. epi-pen, inhaler, etc). **If none indicate by writing None**: _____
**** Required Medication Administration Form must be filed with the School Nurse IF using during athletic event**

Use of any devices/braces/protective wear: _____

Your signature on this form constitutes for your child to participate in athletics and to be baseline tested for concussion management for covered sports. It also signifies that in the event that you cannot be reached in an emergency, you hereby give your permission to the health care provider selected by the coach in charge to hospitalize, secure proper anesthesia, and/or order and injection or surgery for your child.

_____ _____
Signature of Parent/Legal Guardian Date

_____ _____
Signature of School Nurse Date

TURN OVER FOR ADDITIONAL INFORMATION

Updated 5/2018 Original retained in School Health Office - copy provided to Coach

Cincinnatus Central School District
30-day Interval Health History Form For Sports Participation
Please complete Section I,II, III, IV and return to the School Health Office

Prior to the start of practice at the beginning of each sport season, a health history review for each athlete must be conducted unless the student received a full medical examination within 30 days of the start of the season.

SECTION I: TO BE COMPLETED BY THE PARENT OR GUARDIAN

Student: _____ Sport: _____

Grade: _____ DOB: _____ Age: _____ Level (check): ☐ Modified ☐ JV ☐ Varsity

Limitations/Restrictions: ☐ Yes ☐ No …. If "Yes" please explain: _____

SECTION II: TO BE COMPLETED BY THE PARENT OR GUARDIAN
"YES" to any of these questions DOES NOT mean automatic disqualification from the athletic activity. However, it may require a review and approval by our school Medical Director before the student can report to practice.

HISTORY SINCE LAST HEALTH EXAM:

Allergies (Bee Sting, Medication, Food, Latex, etc.)…….. ☐ Yes ☐ No
Does the student carry an Epi-pen for a life threatening allergy?..... ☐ Yes ☐ No
Asthma …… ☐ Yes ☐ No
Does the student carry an inhaler?……. ☐ Yes ☐ No
Concussion/Head injury/Seizures …….. ☐ Yes ☐ No
Recent injury that required medical attention or protective equipment?..... ☐ Yes ☐ No
Recent illness lasting longer than one week (Ie. Mono)…… ☐ Yes ☐ No

Currently taking medication …….. ☐ Yes ☐ No
Diabetes/Hypoglycemia …….. ☐ Yes ☐ No
Heart/Blood Pressure Problems …….. ☐ Yes ☐ No
Heat Exhaustion or stroke …….. ☐ Yes ☐ No
Bleeding Tendency/Anemia …….. ☐ Yes ☐ No
Recent Surgery or Hospitalization…….. ☐ Yes ☐ No
Kidney/Liver Disease…….. ☐ Yes ☐ No
Hearing/Vision Impairment …….. ☐ Yes ☐ No
Wear contact Lenses/glasses……..☐ Yes ☐ No
Is there any medical condition that might be aggravated by playing sports? …… ☐ Yes ☐ No

SECTION III: TO BE COMPLETED BY THE PARENT OR GUARDIAN
Please describe any condition that was answered "YES" in Section II:

_____
_____
_____

SECTION IV: PARENT/GUARDIAN PERMISSION
I clearly understand these questions are asked in order to decide of my child can safely participate on the athletic team listed in Section I of this form. The answers are correct as of this date and he/she has my permission to participate.

Signed: _____ Date: _____

SECTION V: TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE

Date of last Health Exam: _____ Limitation/Restrictions: ☐ Yes ☐ No _____

Sports Participaton (check) …….. ☐ Approved…… ☐ Referred to School Medical Director

Signature of School Nurse: _____ Date: _____

If referred to School Medical Director (check) …… ☐ Approved ☐ Disapproved

Signature of School Medical Director: _____ Date: _____

Updated 5/2018 Original retained in School Health Office - copy provided to Coach