Cincinnatus Central School District
Interscholastic Athletic Program Participation Form
Health Office – Phone (607) 863-3200x2 Fax (607) 863-3546

**** ALL AREAS MUST BE COMPLETED****

Interval Health History Form also **MUST** be completed if the Health Exam was not in the last 30 days.

Student Name:	DOB:	Grade:
Address:		
Sport:	Level (check): ☐ Modified ☐ JV ☐ Varsity	
Date of last Health Exam:	Limitation/Restrictions: ☐ Yes ☐ No	

CONTACT INFORMATION

1) Name:	Relationship:
Contact #1 Home Phone:	Contact #1 Cell Phone:
2) Name:	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 competition for covered sports. **The student, parent or guardian is responsible for notifying the team coach AND School Nurse should an injury occur.**

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. DO NOT INCLUDE MEDICATION TAKEN AT HOME.**

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.

I,_____ give my consent for the above named student-athlete to participate in
Name of Parent/Legal Guardian - Please Print
the Interscholastic Sports selected above subject to approval by the school nurse.

_____ _____
Signature of Parent/Legal Guardian Date

PLEASE SEE REVERSE SIDE

Cincinnatus Central School District
Interscholastic Athletic Program Participation Informed Consent Form
Health Office – Phone (607) 863-3200x2 Fax (607) 863-3546

** ALL AREAS MUST BE COMPLETED**

Athletes Name:	DOB:
Sport:	Level: ☐ Modified ☐ JV ☐ Varsity

SAR-CoV-2 Informed Consent:

- Participation in the higher-risk sport places the student-athlete at risk of exposure to SARS-CoV-2.
- Symptomatic and asymptomatic individuals can spread the virus.
- Masking, distancing, and other mitigation measures reduce, but do not eliminate risk.
- At present, it cannot be predicted who will become severely ill if infected.
- SARS-CoV-2 can lead to serious medical conditions and death for people of all ages.
- The long-term effects of SARS-CoV-2 are, at present, unknown; even people with mild cases may experience long-term complications.
- There is a significant risk of transmission to those in the home of infected student-athletes.
- Older people and people with underlying health conditions are at higher risk of serious disease.

I, parent or legal guardian, have read and understand the risks associated with my child's participation in Interscholastic Sports during the Covid-19 Public Emergency. I agree that my student athlete will fully cooperate with any case/contact investigations and will comply with isolation/quarantine requests if indicated. Ongoing participation will be denied should they fail to cooperate/comply.

_____ _____
Print Name of Parent/Legal Guardian Date

_____ _____
Signature of Parent/Legal Guardian Date

School Nurse/Medical Director Approval: TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE:

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

Sports Participation (check)..... ☐ Approved….. ☐ Referred to School Medical Director ☐ Interval Health Hx complete

Signature of School Nurse: _____ Date: _____

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

Signature of School Medical Director: _____ Date: _____

Cincinnatus Central School District

NYSED Interval Health History for Athletics - Two page form, BOTH pages must be completed

Health Office – Phone (607) 863-3200x2 Fax (607) 863-3546

Name:	DOB:	Age:
Grade:	Level(check): ☐ Modified ☐ JV ☐ Varsity	
Sport:	Date of last Health Exam:	
Limitations/Restrictions: ☐ Yes ☐ No IF yes, please describe: _____ _____		

Health History to Be Completed by Parent/Guardian, Provide Details to Any YES Answers on back.

Medication needed at practice and/or athletic event require proper paperwork filed with the school nurse.

General Health Concerns - Has/Does your Child:	Yes	No
Ever been restricted by a health care provider from sports participation for any reason?		
Have an ongoing medical condition? ❒Asthma ❒Diabetes ❒ Seizures ❒Sickle Cell trait or disease ❒ Other		
Ever had surgery?		
Ever spent the night in the hospital?		
Been diagnosed with Mononucleosis within the last month?		
Have only one functioning kidney?		
Have a bleeding disorder?		
Have any problems with hearing or wear hearing aid(s)?		
Have any problems with vision or has vision in only one eye?		
Wears glasses or contact?		
Allergies	Yes	No
Have a life threatening allergy? Check any that apply: ❒ Food ❒ Insect bite ❒ Latex ❒ Medication ❒ Environmental ❒ other		
Carry an epinephrine auto-injector?		
Breathing (Respiratory) Health	Yes	No
Ever complained of shortness of breath or feeling tired during exercise?		
Wheeze or cough frequently during or after exercise?		
Ever been diagnosed with asthma?		
Use or carry an inhaler or nebulizer?		
Skin Health	Yes	No
Currently have rashed, pressure sores, or other skin problems?		
Have had herpes or MRSA skin infections?		

Concussion/Head injury History - Has/Does your child:	Yes	No
Ever had head injury or concussion?		
Ever had a hit to the head that caused headache, nausea, dizziness, or confusion?		
Ever had headaches with exercise?		
Ever had any unexplained seizures?		
Currently receive treatment of a seizure disorder or epilepsy?		
Devices/Accommodations	Yes	No
Use a brace, orthotic, or other device?		
Have any special devices or prostheses (insulin pump, ostomy bag, etc.)?		
Wear protective eyewear, such as goggles or face shield?		
Injury History	Yes	No
Ever been diagnosed with a stress fracture?		
Ever been unable to move arms/legs or had tingling, numbness, or weakness after being hit or falling?		
Have a bone, muscle, or joint injury causing pain?		
Have joints become painful, swollen, warm or red with use?		
Ever had an injury, pain, or swelling of a joint causing an athlete to miss a game/practice?		
Stomach Health	Yes	No
Ever become ill while exercising in hot weather?		
Have a special diet or need to avoid certain food?		
Have to worry about height/weight?		
Have stomach problems?		
Ever had an eating disorder?		
Family History	Yes	No
Have a relative who's diagnosed with a heart condition or any kind? Including a murmur, cardiomyopathy, tachycardia, etc.		

See Reverse side

Cincinnatus Central School District

NYSED Interval Health History for Athletics - Two page form, BOTH pages must be completed

Health Office – Phone (607) 863-3200x2 Fax (607) 863-3546

Name:	DOB:

Heart History - Has/Does your Child:	Yes	No
Ever passed out during or after exercise?		
Ever complained of lightheadedness 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, racing heart, or have a pacemaker?		
Ever had a diagnostic test for their heart (EKG, stress test, ect.)?		
Ever been diagnosed with a heart condition? Check all that apply: ❒ Heart infection ❒ Heart Murmur ❒ High Blood Pressure ❒ High Cholesterol ❒ Low Blood Pressure ❒ Kawasaki Disease ❒ Other: _____		
Female ONLY	Yes	No
Began menstrual cycle?		
Age periods began: _____		
Have regular periods?		
Date of last menstrual cycle: _____		
Males ONLY	Yes	No
Only have one testicle?		
Have groin pain or a bulge or hernia in the groin?		

COVID-19 Information -	Yes	No
Has your child ever tested positive for COVID-19?		
Was your child symptomatic?		
Did your child see a healthcare provider (HCP) for their COVID-19 symptoms?		
Did your child have any cardiac symptoms (new fast or slow heart rate, chest tightness or pain, blood pressure changes, or HCP diagnosed cardiac condition)? If yes please explain: _____		
Was your child hospitalized? If yes, please provide date(s): _____		
• If yes, was your child diagnosed with Multisystem Inflammatory Syndrome (MISC)?		
• If yes, is your child under a HCP's care for this?		

Please explain fully any questions you answered yes to in the space below. Include dates if known. Use additional pages if necessary.

_____

_____

_____

_____

I understand these questions are asked to determine if my child can safely participate in the Interscholastic Athletic Program noted on the front of this form. I have answered accurately to date, and give my permission for full participation in the chosen activity.

_____ _____

Print Name of Parent/Legal Guardian Date

_____ _____

Signature of Parent/Legal Guardian Date