SPORTS PERMISSION SLIP
MINISINK VALLEY CENTRAL SCHOOL

(<u>MUST</u> be dated and submitted <u>no more than 30 days prior</u> to the start of the season)

PART A: TO BE COMPLETED BY THE PARENT/GUARDIAN

Students Name:_____ Grade :_____ DOB:_____ Gender: M / F

Address:_____ Home Phone: _____

Parent/Guardian Name:_____Cell Phone:_____Work Phone:_____

Emergency Contact:_____ Relationship:_____

Home Phone: _____ Cell Phone:_____ Work Phone:_____

Sport:_____ Mod:_____ Fresh:_____ JV:_____ Var:_____

PART B: PERMISSION

I undersigned, give my son/daughter permission to participate on the athletic team named in PART A of this form.

In case of an injury suffered by my child while participating in the above-stated sports/ activities, I give the coach and/or other school official in charge permission to obtain medical treatment for my child if I cannot be immediately contacted. Following treatment, the coach and/or or other school official will notify me as soon as possible regarding the nature of the injury and any treatment rendered**.**

I have read the Minisink Valley Central School District Interscholastic Rules and Regulations and understand the purpose and direction of this athletic code.

I understand that I will be financially responsible to pay for any equipment not returned at the end of the season.

_____ _____

Signature of Parent/Guardian Date Signature of Student Date

PART C: TO BE COMPLETED BY SCHOOL HEALTH OFFICE

Date of Last Physical:_____

Medical Alerts: _____

_____

_____

_____

_____

Requires Selection Classification: Yes/No

Signed:_____ Date:_____

ANNUAL ATHLETIC PRE-PARTICIPATION HEALTH HISTORY
MINISINK VALLEY SCHOOL DISTRICT

(MUST be dated and submitted no more than 30 days prior to the start of the season)

Student's Name: _____ Sex: M F (circle one) Age: _____ Grade: _____

Date of Birth: _____/_____/_____ Sport: _____ Mod Fresh JV V (circle one)

Provider Name: (Medical Home):_____ Phone: ( ) _____ Fax: ( ) _____

Date of Last Physical: _____/_____/_____

Emergency Contact Information

Name of parent/guardian: _____ Relationship to student: _____

Phone (home): ( ) _____ Phone (work): ( ) _____ Phone (cell): ( ) _____

Emergency contact: _____ Relationship to student: _____

Phone (home): ( ) _____ Phone (work): ( ) _____ Phone (cell): ( ) _____

Directions: Please answer the following questions about the student's medical history by circling the correct response. Explain all "yes" responses on the lines below the questions. Please respond to all questions.

1. Have you ever had or do you currently have:

A. Restriction from sports for health related problem? Yes / No / Don't Know

B. An injury or illness since your last exam? Yes / No / Don't Know

C. A chronic or ongoing illness (such as diabetes or asthma)? Yes / No / Don't Know

1. An inhaler or other prescription medicine to control asthma? Yes / No / Don't Know

D. Any prescribed or over the counter medications that you take on a regular basis? Yes / No / Don't Know

E. Surgery, hospitalization, or any emergency room visit(s)? Yes / No / Don't Know

F. Any **allergies** to medications? Yes / No / Don't Know

G. Any **allergies** to bee stings, polled, latex, or foods Yes / No / Don't Know

1. If yes, circle type of reaction:
   a. Rash
   b. Hives
   c. Breathing or other serious anaphylactic reaction
2. Take any medications (e.g.) EpiPen) for allergy symptoms? (List below) Yes / No / Don't Know

H. Any anemia, blood disorders, sickle cell disease /trait, bleeding tendencies or clotting disorders? Yes / No / Don't Know

I. A blood relative who dies before age 50? Yes / No / Don't Know

Explain all "yes" answers here (include) relevant dates:

_____

_____

_____

List all medications here:

Medication Name	Dosage	

2. Have you ever had, or do you currently have, any of the following head-related conditions:

A. Concussion or head injury (including "bell rung" or a "ding")? Yes / No / Don't Know
B. Memory Loss? Yes / No / Don't Know
C. Knocked out? Yes / No / Don't Know
D. A seizure? Yes / No / Don't Know
E. Frequent or severe headaches (with or without exercise)? Yes / No / Don't Know
F. Fuzzy or blurry vision? Yes / No / Don't Know
G. Sensitivity to light / noise? Yes / No / Don't Know

Explain all "yes" answers here (include) relevant dates:

_____

_____

_____

3. Have you ever had, or do you currently have, any of the following heart-related conditions:

A. Restriction from sports for heart problems? Yes / No / Don't Know
B. Chest pain or discomfort? Yes / No / Don't Know
C. Heart murmur? Yes / No / Don't Know
D. High blood pressure? Yes / No / Don't Know
E. Elevated cholesterol level? Yes / No / Don't Know
F. Heart infection? Yes / No / Don't Know
G. Dizziness or passing out during exercise without known cause? Yes / No / Don't Know
H. Required a heart test (EKG, Echocardiogram, Stress Test, Holter Monitor)? Yes / No / Don't Know
I. Racing or skipped heart beat? Yes / No / Don't Know
J. Unexplained difficulty breathing or fatigue during exercise? Yes / No / Don't Know
K. Any family member (blood relative): Yes / No / Don't Know
    1. Under age 50 with a heart condition? Yes / No / Don't Know
    2. With Marfan Syndrome? Yes / No / Don't Know
    3. Died of a heart problem before age 50? If yes, at what age? _____ Yes / No / Don't Know
    4. Died with no known reason? Yes / No / Don't Know
    5. Died while exercising? If yes, was it during or after? (circle one) Yes / No / Don't Know

Explain all "yes" answers here (include) relevant dates:

_____

_____

_____

4. Have you ever had, or do you currently have, any of the following eye, ear, nose, mouth, or throat conditions:

A. Vision problems? Yes / No / Don't Know
    1. Wear contacts, eyeglasses, or protective eye wear? (circle all the apply) Yes / No / Don't Know
B. Hearing loss or problems?
    1. Wear hearing aids or implants? (circle all the apply) Yes / No / Don't Know
C. Nasal Fracture or frequent nose bleeds? Yes / No / Don't Know
D. Wear braces, retainer, or protective mouth gear? Yes / No / Don't Know
E. Frequent strep or any other conditions of the throat (e.g. tonsillitis) Yes / No / Don't Know

Explain all "yes" answers here (include) relevant dates:

_____

_____

_____

5. **Have you ever had, or do you currently have, any of the following neuromuscular / orthopedic conditions:**
   - A. Numbness, a "burner", "stinger", or pinched nerve? Yes / No / Don't Know
   - B. A sprain? Yes / No / Don't Know
   - C. A strain? Yes / No / Don't Know
   - D. Swelling or pain in muscles, tendons, bones, or joints? Yes / No / Don't Know
   - E. Dislocated joint(s)? Yes / No / Don't Know
   - F. Upper or lower back pain? Yes / No / Don't Know
   - G. Fracture(s), stress fracture(s), or broken bones? Yes / No / Don't Know
   - H. Do you wear any protective braces or equipment? Yes / No / Don't Know

Explain all "yes" answers here (include) relevant dates:

_____

_____

_____

6. **Have you ever had, or do you currently have, any of the following general or exercise related conditions:**
   - A. Difficulty breathing:
     1. During exercise? Yes / No / Don't Know
     2. After running one mile? Yes / No / Don't Know
     3. Coughing, wheezing, or shortness of breath in weather changes? Yes / No / Don't Know
     4. Exercise-induced asthma? Yes / No / Don't Know
        - a. Controlled with medication? (specify_____) Yes / No / Don't Know
        - b. Experience dizziness, passing out, or fainting? Yes / No / Don't Know
   - B. Viral infections (e.g. Mono, Hepatitis, Coxsackie)? Yes / No / Don't Know
   - C. Become tired more quickly than others? Yes / No / Don't Know
   - D. Any of the following skin conditions:
     1. Cold sores / herpes, impetigo, MRSA, ringworm, warts? Yes / No / Don't Know
     2. Sun sensitivity? Yes / No / Don't Know
   - E. Weight gain / loss of 10 pounds or more? Yes / No / Don't Know
     1. Do you want to weigh more or less than you do now? Yes / No / Don't Know
   - F. Ever had feelings of depression? Yes / No / Don't Know
   - G. Heat related problems (e.g. dehydration, dizziness, fatigue, headache)? Yes / No / Don't Know
     1. Heat exhaustion (cool, clammy, damp skin)? Yes / No / Don't Know
     2. Heat stroke (hot, red, dry skin)? Yes / No / Don't Know
     3. Muscle cramps? Yes / No / Don't Know
   - H. Absence or loss of an organ (e.g. kidney, eyeball, spleen, testicle, ovary)? Yes / No / Don't Know

Explain all "yes" answers here (include) relevant date:

_____

_____

_____

7. **Females only:**
   Age of onset of menstruation _____ How many menstrual periods in the last twelve (12) months? _____
   How many missed periods in the last twelve (12) months? _____
8. **Males only**:
   Have you had any swelling or pain in your testicles or groin? Yes / No / Don't Know

Parent/Guardian/Student Signature

I certify that I have been provided information on concussion, (i.e. definition, signs and symptoms) and management, including the importance of a graduated return to cognitive and physical activities. I understand the information provided and have no further questions. I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature and I agree to update the School Nurse with any changes to this information.

_____ _____

Signature, Student <18 Date of Signature

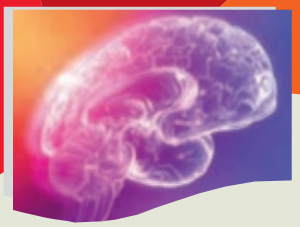
_____ _____

Signature, Parent / Guardian or Student Age ≥ 18 Date of Signature

Parent/Student

DID YOU KNOW?

- Most concussions occur without loss of consciousness.
- Children who have, at any point in their lives, had a concussion have an increased risk for another concussion.
- Young children and teens are more likely to get a concussion and take longer to recover than adults.



Concussion Information

What is a Concussion?

A concussion is a type of traumatic brain injury, or TBI, caused by a bump, blow, or jolt to the head that can change the way your brain normally works. Concussions are usually not life-threatening. Even so, their effects can be serious.

Concussions can also occur from a fall or a blow to the body that causes the head and brain to move quickly back and forth. Some of these symptoms may appear right away, while others may not be noticed for days or months after the injury, or until the person starts resuming their everyday life and more demands are placed upon them.

If your child reports one or more of the symptoms on the list below, he/she should be seen by your healthcare provider. They should not return to play until they are cleared by a medical professional. **It is very important to inform your child's school nurse of any history of concussion/head injuries or of any recent head injuries that occurred outside of school.**

ORANGE-ULSTER BOCES

Edward A. Diana
County Executive

How do I recognize a Concussion?

Signs Observed by Others

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes
- Can't recall events prior to hit or fall
- Can't recall events after hit or fall

Symptoms Reported by Child

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light
- Sensitivity to noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Just not "feeling right" or "feeling down"

What Should I do if a Concussion Occurs?

People with a concussion need to be seen by a health care professional. If you think you or someone you know has a concussion, contact your health care professional.

Your health care professional can refer you to a physician experienced in the management of concussions. Getting help soon after the injury by trained specialists may speed recovery.

ORANGE COUNTY NEW YORK 1 NOVEMBER 1683

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For more information, please contact:
your child's School Nurse or your child's Pediatrician

Concussion Danger Signs

Visit the emergency department right away if they received a bump, blow, or jolt to the head or body, and:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that not only does not diminish, but gets worse
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people or places
- Becomes increasingly confused, restless, or agitated
- Has unusual behavior
- Loses consciousness (even a brief loss of consciousness should be taken seriously)

What Can I Do to Help Feel Better After a Concussion?

Although most people recover fully after a concussion, how quickly they improve depends on many factors. These factors include how severe their concussion was, their age, how healthy they were before the concussion, and how they take care of themselves after the injury. Some people who have had a concussion find that at first it is hard to do their daily activities, their job, to get along with everyone at home, or to relax.

Rest (physical & cognitive) is very important after a concussion because it helps the brain to heal.

Ignoring your symptoms and trying to "tough it out" often makes symptoms worse. Be patient because healing takes time. Only when your symptoms have reduced significantly, in consultation with your health care professional, should you slowly and gradually return to your daily activities, such as work or school. If your symptoms come back or you get new symptoms as you become more active, this is a sign that you are pushing yourself too hard. Stop these activities and take more time to rest and recover. As the days go by, you can expect to gradually feel better.

What Can I do to Help Prevent Traumatic Brain Injury?

There are many ways to reduce the chances of sustaining a traumatic brain injury, including:

- Buckling your child in the car using a child safety restraint seat, or seat belt (according to the child's height, weight, and age).
- Wearing a seat belt every time you drive or ride in a motor vehicle.
- Never driving while under the influence of alcohol or drugs.

Wearing a helmet and making sure your children wear helmets when:

- Riding a bike, motorcycle, snowmobile, scooter, or all-terrain vehicle;
- Playing a contact sport, such as football, ice hockey, or boxing
- Using in-line skates or riding a skateboard
- Batting and running bases in baseball or softball
- Riding a horse
- Skiing or snowboarding.

Making living areas safer for children by:

- Installing window guards to keep young children from falling out of open windows
- Using safety gates at the top and bottom of stairs when young children are around.
- Making sure the surface on your child's playground is made of shock-absorbing material, such as hardwood mulch or sand.