

WILLIAM FLOYD UNION FREE SCHOOL DISTRICT
of the
MASTICS-MORICHES-SHIRLEY
240 Mastic Beach Road
Mastic Beach NY 11951

INTERSCHOLASTIC SPORTS PROGRAM

Dear Parent,

According to state law all students participating in interscholastic sports *must* have a physical examination. The examination will be given by our school physician. The process requires two (2) days. The first day includes screenings done by the school nurses and coaches. The second day includes the exam by the school physician. It will be the responsibility of your son/daughter to have the testing and exam done at the prescribed time and date.

THE PHYSICAL EXAM MUST BE COMPLETED AND PASSED BEFORE A STUDENT MAY PARTICIPATE IN TRY-OUTS.

Please complete the attached form and have your son/daughter return it at the time of testing.

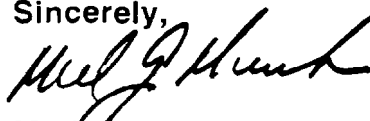
1. Student medical history (must be completed by parent/guardian and signed).
2. Parental consent *must* indicate sport and parent *must* sign in ink.

The physical exam (back side of form) is to be used by the school physician and nurses, although the top of the form should be filled out by the student.

Sport physicals are valid for one year. You will be required to sign another consent to participate if your son/daughter plans to join another sport during the year.

STUDENTS WILL BE UNABLE TO OBTAIN A SCHOOL PHYSICAL EXAM UNLESS THIS FORM IS COMPLETED AND RETURNED.

Sincerely,



Mark G. Mensch

Coordinator of Health, Physical Education,
Consumer & Family Sciences & Athletics

STUDENT ACCIDENT INSURANCE PROGRAM

CLAIM FILING PROCEDURES

The children in this school district are covered against accidental injury under a school-time plan of insurance.

Your child is covered while:

- attending school, during school hours, including summer academic classes.
- attending school-sponsored and school-supervised activities during the school term.
- traveling directly to and from school for either of the above.
- attending and traveling to and from religious services and religious education classes.

NOTE: THIS COVERAGE IS IN EXCESS OF ANY OTHER INSURANCE COVERAGE YOU MAY HAVE ON YOUR CHILD. THIS POLICY DOES NOT COVER CRUTCHES, BRACES AND OTHER ORTHOPEDIC APPLIANCES.

The policy specifies that loss must be incurred within 30 days of the date of the accident; further, that the claim must be submitted as soon as possible.

YOU MUST SUBMIT THE CLAIM TO YOUR OWN INSURANCE COMPANY FIRST! Your school insurance plan cannot make payment on your claim until they have received proof of payment or denial of benefits from your own insurance company.

IN ADDITION, THIS POLICY HAS A DEDUCTIBLE CLAUSE.

***DEDUCTIBLES** - Each claim is subject to a \$25 deductible, the payment of which will be the parent's responsibility.

CLAIM PROCEDURES- PHYSICAL EHAM FORM
Revised 3/94

NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).

WILLIAM FLOYD SCHOOL DISTRICT HEALTH APPRAISAL FORM

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

School: _____ Gender: M F Grade: _____

IMMUNIZATIONS / HEALTH HISTORY

Immunization record attached
 No immunizations given today
 Immunizations given since last Health Appraisal:

Sickle Cell Screen: Positive Negative Not done Date: _____
 PPD: Positive Negative Not done Date: _____
 Elevated Lead: Yes No Not done Date: _____
 Dental Referral Yes No Not done Date: _____

Significant Medical/Surgical History: See attached _____

Specify current diseases: Asthma Diabetes: Type 1 Type 2 Hyperlipidemia Hypertension
 Other: _____

Allergies: LIFE THREATENING Food: _____ Insect: _____ Other: _____
 Seasonal Medication: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Pulse: _____ Blood Pressure: _____ Date of Exam: _____

Referral

Body Mass Index: _____ Percentile _____	Vision - without glasses/contact lenses	R	L	
	Vision - with glasses/contact lenses	R	L	
	Vision - Near Point	R	L	
	Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R	L	

EXAM ENTIRELY NORMAL Tanner: I. II. III. IV. V. Scoliosis: Negative Positive: _____

Specify any abnormality (use reverse of form if needed): _____

URINALYSIS: _____ GLUCOSE: _____ PROTEIN: _____

MEDICATIONS

Medications (list all): None Additional medications listed on reverse of form

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

Please note separate medication administration form must be completed for medication that is to be taken in school.

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:
 ___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
 ___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

Specify medical accommodations needed for school: _____ None

Known or suspected disability: _____ Please monitor

Restrictions: _____ Please monitor

Protective equipment required: Athletic Cup Sport goggles/impact resistant eyewear Other: _____

(Stamp below)

Provider's Signature: _____ Phone: _____

Provider's Name/Address: _____ Fax: _____

Parent Signature: _____ Date: _____

This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director. Rev. 10/3/07

WILLIAM FLOYD HIGH SCHOOL ATHLETIC DEPARTMENT SPORTS PARENT PAGE

PART 1: MEDICAL-SURGICAL HISTORY

NAME: _____ **DOB:** _____ **GRADE:** _____

ALL QUESTIONS MUST BE ANSWERED YES OR NO WITH EXPLANATION IF NEEDED, USE INK ONLY

	<u>NO</u>	<u>YES</u>	<u>DATE</u>	<u>EXPLAIN</u>
1. EYE DISORDER (VISION)				
2. EAR DISORDER (HEARING)				
3. NOSE DISORDER				
4. THROAT DISORDER				
5. LIVER/SPLEEN PROBLEMS				
6. HEART MURMUR				
RHEUMATIC FEVER				
7. LUNGS: PNEUMONIA				
BRONCHITIS				
ASTHMA				
8. KIDNEY/BLADDER DISORDER				
9. ABDOMINAL, INTENSTINAL DISORDER				
10. HERNIA				
11. UNDESCENDED TESTICLES				
12. BONES/JOINTS: FRACTURES				
DISLOCATIONS/SPRAINS				
13. MUSCLE, NERVE DISORDERS				
14. EPILEPSY, SEIZURES				
15. HEAD INJURY/CONCUSSION				
16. ALLERGIES				
17. HOSPITAL ADMISSIONS				
18. MEDICATIONS PRESENTLY USED				
19. OTHER CHRONIC CONDITION(S)				
20. ANY OPERATIONS/SURGERIES				

NAME OF STUDENT'S HEALTHCARE PROVIDER _____ PHONE _____

PART 2 – PERMISSION SLIP

I give my son/daughter permission to participate in the interscholastic sports program at William Floyd School District. I give him/her permission to travel to away games and/or meets under the supervision of a coach. I will assume the responsibility for supplies and equipment given to my son/daughter that is not returned. I understand that participation in athletics can be hazardous to the health of my child and that my son/daughter and I are responsible for notifying the team coach and school nurse should an injury occur. I am aware of the school district's interscholastic sports insurance program and I assume responsibility for any lenses or orthodontic appliances that my child uses should they be lost or broken.

I give my son/daughter permission to participate in _____ (name of sport)

Parent signature _____ Date: _____

*Please note: this form must be completed no sooner than 2 weeks prior to every sport season. This form must be submitted to the school nurse by 12:00 noon for same-day processing.