SEAFORD PUBLIC SCHOOLS
SPORTS PHYSICAL REQUEST

_____PLEASE HAVE MY CHILD EXAMINED BY THE SCHOOL PHYSICIAN

_____SPORTS PHYSICAL WILL BE DONE BY PRIVATE PHYSICIAN (MUST BE DONE AND RETURNED BY THE START OF THE SPORT SEASON; MUST BE DATED WITHIN ONE YEAR OF CURRENT SPORT SEASON)

SIGNATURE OF PARENT_____DATE_____

SEAFORD MIDDLE SCHOOL/HIGH SCHOOL

COACH'S AUTHORIZATION FOR TEAM MEMBERSHIP AND PARTICIPATION

SPORT _____ ___ Middle School ___JV ___Varsity

STUDENT NAME_____

DOB_____GRADE_____AGE_____Year you began or will begin 9th grade_____

ADDRESS:_____

Parents Name(s):_____

Home Phone #_____Cell# _____

Primary Physician's Name & Phone #_____

Emergency Contact Person & Phone #_____

Known allergies_____

Parents Signature_____Date_____

Student Signature_____Date_____

Below to be completed by Nurse and Athletic Director ONLY

Nurse's Signature_____Date_____

Physical Exam Date_____

AthleticDirectorSignature_____Date_____

SEAFORD MIDDLE SCHOOL/HIGH SCHOOL ATHLETICS

Dear Parent or Guardian:

Your son/daughter has elected to participate in interscholastics. To make sure that your son/daughter has your permission and in order to make a proper medical evaluation of your child, THIS FORM MUST BE FILLED OUT COMPLETELY AND RETURNED TO THE SCHOOL NURSE BEFORE YOUR CHILD WILL BE GIVEN APPROVAL TO PARTICIPATE.
Thank you for your cooperation.
Respectfully,

Kevin Witt, Director Physical Education, Health & Athletics

SPORTS CANDIDATES HEALTH HISTORY
(to be completed by parent or guardian)

NAME_____GRADE____DATE OF BIRTH_____DATE_____

	Yes	No
1. Has student ever had any fractures, dislocations, severe sprains or other serious injuries?	___	___
2. Has student ever been hospitalized?	___	___
3. Has student ever had surgery?	___	___
4. Does student have any allergies?	___	___
5. Does student take any medication now?	___	___
6. Has student ever been refused permission to participate in athletics?	___	___
7. Does student wear glasses?	___	___
Contact lenses	___	___

PLEASE EXPLAIN ANY 'YES' ANSWERS TO THE ABOVE QUESTIONS IN THE SPACE BELOW (include dates)

IF YOU HAVE BEEN ABSENT FROM SCHOOL FOR (5) FIVE CONSECUTIVE DAYS, YOU SHOULD PRESENT A NOTE FROM YOUR PHYSICIAN THAT YOU ARE ABLE TO PRACTICE. YOU MAY ALSO BE RE-EVALUATED BY THE SCHOOL PHYSICIAN BEFORE PARTICIPATING.

PLEASE CHECK IF YOUR CHILD HAS EVER HAD ANY OF THE FOLLOWING:

__Anemia
__Asthma
__Diabetes
__Chronic Cough
__Eye Injuries
__High Blood Pressure
__Heart Disease/Conditions
__Heart Murmur
__Rheumatic Fever
__Hearing Loss
__Kidney Disease
__Prolonged Bleeding
__Seizures
__Head Injuries/Concussions

PLEASE GIVE DATES AND EXPLAIN IF YOU CHECKED ANY OF THE ABOVE

PARENTAL AUTHORIZATION FOR MEDICAL TREATMENT:

I/We_____the parent/guardian of_____
hereby acknowledge that I/We may not be available to provide a consent for medical treatment in the event our child is sick or becomes injured during the athletic participation authorized above. In the event I/We are not available for such consent, it is my/our desire to have the best available medical treatment for my/our child. This form hereby authorizes the District professional(s) named below to act on my/our behalf with respect to any required medical treatment decisions and consents until such time as I/We are able to provide these items. Notice is hereby given to any qualified medical personnel that this authorization is currently in effect, and such personnel are directed to act upon such authorization without delay.

Designated District Agent: Kevin Witt Child's Coach
District Position Held by Agent: Athletic Director or Coach
Agent's Address and Telephone Number: Seaford High School – 1575 Seaman's Neck Road, Seaford, NY 11783
516-592-4350

_____ _____
Parent/Guardian Signature Date

PLEASE COMPLETE REVERSE SIDE

SEAFORD UNION FREE SCHOOL DISTRICT
PARENTAL/GUARDIAN CONSENT-ATHLETIC PARTICIPATION AND MEDICAL TREATMENT

STUDENT:_____SEX_____
ADDRESS:_____
GRADE:_____BIRTH DATE:_____

Dear Parent/Guardian:

Your child has expressed a desire to participate in our interscholastic sports program. It is important that you and your child understand the goals of the program and agree to abide by the rules established by the district for the benefit of those who participate.

WARNING: PARTICIPATION IN ATHLETICS INCLUDES A RISK OF SERIOUS INJURY, CONCUSSIONS, PERMANENT PARALYSIS OR DEATH. YOU ARE HEREBY FURTHER ADVISED THAT ATHLETIC PARTICIPATION WILL INVOLVE TRAVEL IN SCHOOL DISTRICT VEHICLES. NO TRAVEL WILL BE PERMITTED OTHER THAN IN SCHOOL DISTRICT VEHICLES, AND ALL TRAVEL INCLUDES SERIOUS RISK OF INJURY.

1. Interscholastic sports are a part of a broad extracurricular program designed to teach students certain skills and reinforce concepts of self-worth (achievement), cooperative efforts (teamwork), and ethical decision making (sportsmanship).
2. ALL PARTICIPANTS MUST RECEIVE A PHYSICAL EXAMINATION BY THE SCHOOL PHYSICIAN OR A PRIVATE PHYSICIAN PRIOR TO THE START OF PRACTICE. Please consult your physician regarding your child's protection against tetanus. If there is a question about your child's eligibility for physical reasons, it will be discussed with you prior to the start of the program.
3. School insurance for the medical treatment of sports related-injuries is applicable only after the parents' health insurance has been used. The District insurance is called scheduled, excess coverage and generally will not pay the full cost of treatment. The cost of medical benefit insurance on a total basis would be so costly as to effectively eliminate the program.
4. Within the first three team meetings the coach will explain the attendance and training rules as well as eligibility rules for participation. In addition to the strict observance of these rules, your child will be expected to continue to meet all regular school obligations of citizenship and academic achievement.
5. School equipment issued to your child for participation is his or her responsibility and must be returned promptly at the close of the season. *Reimbursement from the student will be expected for loss or destruction beyond ordinary wear and tear.*
6. IN THE EVENT THAT YOUR CHILD BECOMES SICK OR RECEIVES AN INJURY DURING ATHLETIC PARTICPATION, ALL REASONABLE EFFORTS WILL BE MADE TO CONTACT YOU AND OBTAIN ANY REQUIRED CONSENTS FOR MEDICAL CARE. IN SITUATIONS WHERE YOU CANNOT BE CONTACTED FOR SPECIFIC CONSENT FOR TREATMENT, AND SUCH DELAY CREATES A RISK TO YOUR CHILD'S LIFE OR HEALTH, THE DISTRICT REPRESENTATIVES WILL USE THE AUTHORITY YOU GRANT THEM BY THIS FORM TO OBTAIN APPROPRIATE MEDICAL CARE AND TREATMENT FOR YOUR CHILD.
7. This consent form is valid for all athletic teams in which your child participates during the school year.

I have read and understand the above rules and regulations pertaining to participation in the Seaford Public Schools athletic program. I agree to abide by these rules and regulations. I further acknowledge that I agree to adhere to the school district's policy on concussion management. This information is posted on the Seaford School district website's Athletic Department/Athletic Trainer section. I give permission for my child to participate in interscholastic sports for this school year.

_____ _____
Parent's Signature Date

_____ _____
Student's Signature Date