



THINKING ABOUT GOING OUT FOR A FALL SPORT?

1. Who needs a Fall sports physical?

Physical examinations are **REQUIRED** for all students participating in interscholastic sports. Physical information is updated on a season-by-season basis. Please do not wait for one season to be finished to recertify for the next sports season.

*******Students in grades 7 & 8 who wish to tryout for a Freshman, JV or Varsity sport MUST COME to Sports Physicals to have maturation screening done*******

2. Where can I get the forms?

Spring sports packets are available in the High Schools and Middle Schools at the following locations: Main Offices, Guidance Offices and Health Offices. You can also go to www.shenet.org and click on sports.

3. Does Shenendehowa offer Sports Physicals?

Yes, physicals will be offered on **Monday, August 3rd, Thursday, August 6th and Monday, August 10th from 5:00 – 6:30 p.m.** in the High School East Building Health office. Athletes must report no later than 6:30 p.m.

- These are the **ONLY** dates for fall sports physicals.
- A Health History Form completed and signed by the parent and the student must be presented at the time of the physical. This form must be dated no more than two days prior to the physical. Physicals cannot be done without this form.
- Private sports physical **CANNOT** be submitted during school sports physical night.
- **NOTE:** Special information for students with **ASTHMA**: please see question #5.

4. What if I plan to go to my own doctor?

A private physical is accepted if completed after August 1, 2008 and the physician has completed the SHENENDEHOWA SCHOOL/SPORTS PHYSICAL FORM. This also includes the Health History signed by the parent. Students who have a private physical must do the following:

- Private physicals must be approved by the school nurse before an athlete can practice. Coaches **CANNOT** accept or approve physical forms. Nurses will be available at the scheduled times during July and August for this purpose. Private Physical Clearance, Grades 7 – 12, in the High School East Building begins July 30th. Please refer to the Sports Calendar on the back of this announcement for dates and hours when nurses will be available to approve Private Physicals and answer questions about Fall Sports Clearance. Private physicals **WILL NOT** be accepted during Sports Physical Nights.
- Modified Sports Clearance will take place on Thursday, August 27th in the Koda Health Office from 5:00 to 7:00 p.m.
- Coaches **CANNOT** accept or approve physical forms.
- **Recertification Form/Interval Health History HPE 7:** If the sports physical is done prior to July 19, 2009, this form must be completed and signed by a parent and the student and dated within two days of the student coming to spring sports clearance.
- The Athletic office is located in High School East, telephone 881-0390.

5. What if my athlete must carry medication?

If you will have medication in the nurse's office **OR** if you plan to carry **ANY** medication during the school year, for example, an Inhaler, EPI PEN, prescribed medication or **ANY** over the counter medication; the **MEDICATION FORM-HM2** must be filled out. This form **MUST** be completed by physician and parent.

Please have your doctor check off that you may carry medication if you will be doing so. Medication forms MUST BE dated after July 1, 2009.

6. A sports physical meets the requirement for the 7th and 10th grade physical.

OVER



**Must be submitted with the physical*

For Parent/Guardian Use

This form should be completed prior to the physical, signed by parent and student, and available at the time of the physical. If not completed and returned, the school physician may not give final approval to play.

Last Name _____ First _____ D.O.B. _____ Sport: _____
 School Yr. _____ Grade _____ School Building _____ Age _____ Sex: M / F

ALL "YES" ANSWERS MUST BE EXPLAINED (BOX AT BOTTOM)

Yes No

1.	Have you had a medical illness or injury since your last check up or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Have you ever been hospitalized overnight?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Will you be carrying any medication or pills or inhaler in school or sport activities?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Have you ever taken any supplements or vitamins to help you improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Do you have any allergies (for example: to pollen, medicine, food, or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Have you ever had a rash or hives develop during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Have you ever been dizzy or passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
10.	Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
11.	Have you ever had high blood sugar (diabetes)?	<input type="checkbox"/>	<input type="checkbox"/>
12.	Do you tire more easily than you feel you should?	<input type="checkbox"/>	<input type="checkbox"/>
13.	Have you ever been diagnosed with anemia?	<input type="checkbox"/>	<input type="checkbox"/>
14.	Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>
15.	Have you had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
16.	Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
17.	Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>
18.	Have you had a severe viral infection (for example: myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
19.	Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>
20.	Have you ever been diagnosed with blood or bleeding disorders?	<input type="checkbox"/>	<input type="checkbox"/>
21.	Do you have absent one kidney, testicle, eye, or ear?	<input type="checkbox"/>	<input type="checkbox"/>
22.	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>
23.	Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
24.	Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>
25.	Have you ever had a seizure or convulsion?	<input type="checkbox"/>	<input type="checkbox"/>
26.	Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>
27.	Have you ever had numbness or tingling in your arms, hands, legs, or feet from a stinger, burner, or pinched nerve, or other condition?	<input type="checkbox"/>	<input type="checkbox"/>
28.	Have you ever had heat cramps, heat exhaustion, or heat stroke?	<input type="checkbox"/>	<input type="checkbox"/>
29.	Do you cough, wheeze, or have trouble breathing during or after activity?	<input type="checkbox"/>	<input type="checkbox"/>
30.	Do you have asthma or lung disease?	<input type="checkbox"/>	<input type="checkbox"/>
31.	Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
32.	Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example: knee brace, foot orthotics, retainer on your teeth, hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>
33.	Have you ever had any problem with your ears or hearing?	<input type="checkbox"/>	<input type="checkbox"/>
34.	Do you wear glasses, contacts, or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>
35.	Do you have any other problem with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>

		Yes	No
36.	Have you ever had dental health problems or loss of tooth enamel?	<input type="checkbox"/>	<input type="checkbox"/>
37.	Have you broken or fractured any bones or dislocated any joints, or been diagnosed with a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>
38.	Have you ever had a sprain, strain, or swelling after injury or any other problems with pain or swelling in muscles, tendons, bones, or joints that has kept you from participating in sports? <i>If yes, check appropriate box and explain below.</i>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Head <input type="checkbox"/> Back <input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Finger <input type="checkbox"/> Thigh <input type="checkbox"/> Shin/Calf <input type="checkbox"/> Foot <input type="checkbox"/> Neck <input type="checkbox"/> Chest <input type="checkbox"/> Upper Arm <input type="checkbox"/> Forearm <input type="checkbox"/> Hand <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Ankle		
39.	Have you experienced abdominal discomfort, constipation, diarrhea, and/or bloating?	<input type="checkbox"/>	<input type="checkbox"/>
40.	Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
41.	Has there been any unexplained weight loss or weight gain during the past six months?	<input type="checkbox"/>	<input type="checkbox"/>
42.	Are you uncomfortable with your body weight?	<input type="checkbox"/>	<input type="checkbox"/>
43.	Are you currently following any particular diet or weight reducing plan?	<input type="checkbox"/>	<input type="checkbox"/>
44.	Do you diet frequently?	<input type="checkbox"/>	<input type="checkbox"/>
45.	Do you avoid eating certain food groups?	<input type="checkbox"/>	<input type="checkbox"/>
46.	Have you ever tried to control weight by vomiting, using laxatives, diuretics, or diet pills?	<input type="checkbox"/>	<input type="checkbox"/>
47.	Do you have a history of eating disorders?	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
	FEMALES ONLY	<input type="checkbox"/>	<input type="checkbox"/>
48.	Has there been a recent change in menstrual patterns?	<input type="checkbox"/>	<input type="checkbox"/>
49.	At what age did you experience your first menstrual period? _____		
50.	When was your most recent menstrual period? ___/___/___		
51.	How much time do you usually have from the start of one period to the start of another? _____		
52.	How many periods have you had in the last year? _____		
53.	What was the longest time between one menstrual cycle and the next in the last year? _____		

Explain "Yes" Answers Here (Identify each answer with question number)

I, the undersigned, clearly understand these questions are asked in order to decide if my child can safely participate on the athletic team named above. The answers are complete and correct as of this date and he/she has my permission to participate.

<hr/> Parent/Guardian Signature	<hr/> Student Signature	<hr/> Date *Must be completed & dated within 2 days of the physical
<hr/> Home Phone	<hr/> Work Phone	<hr/> Cell Phone

For School Nurse Use:			
AB		PE	Nurse

Shenendehowa Central School District

Health Appraisal/Sports Physical Form- K-12th Grade

Students in kindergarten, 2nd, 4th, 7th & 10th grades and all new students are required by Education Law to have a physical. Physicals may be done no earlier than 12 months prior to entrance to school.

Name: _____ Date of Birth: _____
 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: _____

Significant Medical/Surgical History: See attached _____

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

PHYSICAL EXAM

Check here if entire exam normal
 Height: _____ Weight: _____ Blood Pressure: _____ Date of Exam: _____ Referral

Body Mass Index: _____	Vision - without glasses/contact lenses	R	L	
Weight Status Category (BMI Percentile):	Vision - with glasses/contact lenses	R	L	
<input type="checkbox"/> less than 5 th <input type="checkbox"/> 5 th through 49 th <input type="checkbox"/> 50 th through 84 th	Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R	L	
<input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th and higher				

Check (✓) Equals Normal Finding

General Appearance: _____ Eyes: _____
 Skin: _____ Ears: _____
 Head: _____ Lungs: _____
 Nose, Throat, Teeth: _____ Heart: _____
 Lymph Node/Thyroid: _____
 Abdomen: _____
 Genitalia: _____ Tanner: I. ____ II. ____ III. ____ IV. ____ V. ____
 Musculoskeletal: _____ Scoliosis: Negative Positive: _____
 Neurological: _____

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

Medical Clearance: Free from contagions & physically qualified for all physical education, sports (includes all contact/collision, etc), playground, work & school activities OR only as checked:

___ Limited contact: cheerlead, gymnastics, ski(Alpine &XC), volleyball, diving, fence, baseball, floor hockey, softball, basketball, handball.
 ___ Strenuous/Noncontact: indoor track, cross country, tennis, track & field, swimming, rope jump, weight train
 ___ Non-contact: badminton, bowl, golf, archery, riflery, dance, walking.

Specify medical accommodations needed for school: _____ None

Known or suspected disability: _____

Restrictions: _____

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

OPTIONAL INFORMATION, if known

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

Provider's Signature: _____ Phone: _____ (Stamp below)

Provider's Name/Address: _____ Fax: _____

The school nurse has permission to share information with staff who work with my child.

Parent Signature: _____ Date: _____



Shenendehowa High School

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In an effort to cut down on the expenses associated with copying seasonal sports packets, we have provided links below to the forms that students need each season to participate in a sport at Shenendehowa. You can also find links to these forms at the bottom of our sports page at <http://www.shenet.org/district/sports/sports.htm>.

See your **school nurse** to find out **exactly** what you will need to participate in your chosen sport. You will not be allowed to practice or try out if you are not cleared to participate.

Physical (Form HPE-5)	http://www.shenet.org/district/policy_and_forms/HA1_HPE5school_sportphys.htm
Recertification (Form HPE-7)	http://www.shenet.org/district/policy_and_forms/HPE7sportrecert.htm
Annual Health History (Form HPE-6)	http://www.shenet.org/district/policy_and_forms/HPE6sporthealhist.htm
Medication Administered in School (Form HPE-2)	http://www.shenet.org/district/policy_and_forms/HM2medsinschool.htm

If you have a current physical on file, you will need to complete the HPE-6 and the HPE-7 and receive a clearance form from your school's nurse. HPE-6 and HPE-7 forms should be completed and signed within three days of clearance

If you plan on attending School Physicals, you will need to complete the HPE-6 form and bring it with you on the scheduled sports physical date. The HPE-6 form should be completed and signed within two days of physicals performed by the school physician.

IF YOU PARTICIPATE IN MULTIPLE SEASONS, PLEASE DO NOT WAIT FOR ONE SEASON TO END TO RECERTIFY FOR THE NEXT. Post-season competition sometimes carries over into the following season.