STATEN ISLAND ACADEMY INTERSCHOLASTIC ATHLETICS

PARENT/STUDENT CONSENT FORM – UPPER SCHOOL

Student's Name: _____ Grade: _____

Address: _____ Date of Birth: _____

Parent/ Guardian #1: _____

Parent / Guardian #2: _____

PARENT / GUARDIAN CONSENT:

I hereby give permission for my child to participate on the following team: **CIRCLE ONE ONLY**

FALL: CROSS COUNTRY SOCCER GIRLS' TENNIS GIRLS' VOLLEYBALL

WINTER: BASKETBALL SWIMMING

SPRING: BADMINTON BASEBALL GOLF GIRLS' LACROSSE

SOFTBALL BOYS' TENNIS BOYS' VOLLEYBALL

I understand that Staten Island Academy will not assume responsibility should an accident occur to my child during participation in any phase of the athletic program. I also understand that participation in this sport may involve strenuous physical activity and bodily contact and, consequently, may result in injuries causing complete or partial paralysis, permanent physical or mental incapacitation, or loss of life. I also understand that my child will be obligated to attend all practices and that failure to do so may constitute grounds for exclusion from the team. I acknowledge that I have read and understand this warning. I give my child permission to travel to and from all contests, scrimmages, and practices in or out of New York City, and agree to be responsible for the return of all equipment issued by the school to him/her. I also understand that it is necessary for my child to have had and passed a physical exam given by a physician and to have a record on file in the school before trying out, practicing, or competing in interscholastic activities. I also agree to inform the school of any change in my child's medical or physical condition, which develops or is discovered at any time after the date this document is signed.

STUDENT CONSENT:

I hereby request permission to enroll as a candidate for a place on each of the teams noted above. I understand that in order to participate, I must:

1) Have on file in the Athletic Office this consent form signed by a parent/guardian, giving approval.
2) Pass a physical examination given by a physician and have a record of that exam on file at the Academy.
3) Agree to obey all regulations, including those pertaining to practice periods and team rules as established by the coaches, and to conduct myself with class and dignity, both on and off the fields and/or courts at all times. Failure to do so may result in suspension or dismissal from the team.
4) Be responsible for the care and safe return of all school equipment issued to me, and I will personally bring it to the coach or appropriate member of the Athletic Department.
5) **Have completely read and understand this Consent Form and the Athletic Handbook on the Academy website**.

_____ _____

Signature of Student Date

_____ _____

Signature of Parent / Guardian Date

STATEN ISLAND ACADEMY INTERSCHOLASTIC ATHLETICS

PARENT/STUDENT CONSENT FORM – MIDDLE SCHOOL

Student's Name: _____ Grade: _____

Address: _____ Date of Birth: _____

Parent/ Guardian #1: _____

Parent / Guardian #2: _____

PARENT / GUARDIAN CONSENT:

I hereby give permission for my child to participate on the following team: - **CIRCLE ONE ONLY**

FALL: SOCCER (CO-ED) GIRLS' VOLLEYBALL

WINTER: BASKETBALL SWIMMING

SPRING: BASEBALL SOCCER SOFTBALL

I understand that Staten Island Academy will not assume responsibility should an accident occur to my child during participation in any phase of the athletic program. I also understand that participation in this sport may involve strenuous physical activity and bodily contact and, consequently, may result in injuries causing complete or partial paralysis, permanent physical or mental incapacitation, or loss of life. I also understand that my child will be obligated to attend all practices and that failure to do so may constitute grounds for exclusion from the team. I acknowledge that I have read and understand this warning. I give my child permission to travel to and from all contests, scrimmages, and practices in or out of New York City, and agree to be responsible for the return of all equipment issued by the school to him/her. I also understand that it is necessary for my child to have had and passed a physical exam given by a physician and to have a record on file in the school before trying out, practicing, or competing in interscholastic activities. I also agree to inform the school of any change in my child's medical or physical condition, which develops or is discovered at any time after the date this document is signed.

STUDENT CONSENT:

I hereby request permission to enroll as a candidate for a place on each of the teams noted above. I understand that in order to participate, I must:

1) Have on file in the Athletic Office this consent form signed by a parent/guardian, giving approval.
2) Pass a physical examination given by a physician and have a record of that exam on file at the Academy.
3) Agree to obey all regulations, including those pertaining to practice periods and team rules as established by the coaches, and to conduct myself with class and dignity, both on and off the fields and/or courts at all times. Failure to do so may result in suspension or dismissal from the team.
4) Be responsible for the care and safe return of all school equipment issued to me, and I will personally bring it to the coach or appropriate member of the Athletic Department.
5) **Have completely read and understand this Consent Form and the Athletic Handbook on the Academy website**.

_____ _____

Signature of Student Date

_____ _____

Signature of Parent / Guardian Date

STATEN ISLAND ACADEMY
EMERGENCY CONTACT FORM

To Be Completed by the Parent or Guardian:

Student Name: _____ _____ _____ Sex: ☐ Male ☐ Female
Last First Middle

Address: _____ Birth Date ☐☐-☐☐-☐☐

City/State/Zip _____ Grade _____

Home Phone # _____ Mother's Work # _____

Father's Work # _____ Additional Phone# _____

Please list contact person(s) who can be reached, if above are unavailable, who can give permission for emergency treatment:

Name: _____ Phone _____ Relationship _____

Name: _____ Phone _____ Relationship _____

Does your child wear contact lenses? ☐ Yes ☐ No

Date of last tetanus shot: ☐☐-☐☐-☐☐

List any medications your child may be taking:

_____

List any allergic reactions that we should be aware of:

_____

Additional information which would be helpful in an emergency:

_____

Please read and sign the following statement:

I, _____, do hereby give permission for an attending emergency physician to give medical treatment to my child, _____, in case of an emergency in my absence. I am executing a written copy and a carbon copy of this permission, and the physician relying on this permission my do so even though what is being exhibited is a carbon or photocopy of the same and a carbon or photocopy of my signature.

Parent/Guardian Signature: _____ Date: _____

Staten Island Academy
715 Todt Hill Road
Staten Island, NY 10304

Recommended NYSED Interval Health History for Athletics–Two Page Form

Both pages must be completed.

Student Name:	DOB:
School Name:	Age:
Grade (check): ☐7 ☐8 ☐9 ☐10 ☐11 ☐12	Level (check): ☐ Modified ☐ Fresh ☐ JV ☐ Varsity
Sport:	Limitations: ☐ Yes ☐ No
Date of last health exam:	Date form completed:

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

Medicines needed at practice and/orathletic event require the properpaperwork, contact school with questions.

Has/Does your child:

General Health Concerns	No	Yes
1. Ever been restricted by a health care provider from sports participation for any reason?	☐	☐
2. Have an ongoing medical condition? ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Sickle Cell trait or disease ☐ Other		
3. Ever had surgery?	☐	☐
4. Ever spent the night in a hospital?	☐	☐
5. Been diagnosed with Mononucleosis within the last month?	☐	☐
6. Have only one functioning kidney?	☐	☐
7. Have a bleeding disorder?	☐	☐
8. Have any problems with his/her hearing or wears hearing aid(s)?	☐	☐
9. Have any problems with his/her vision or has vision in only one eye?	☐	☐
10. Wear glasses or contacts?		☐
Allergies		
11. Have a life-threatening allergy? Check any that apply: ☐ Food ☐ Insect Bite ☐ Latex ☐ Medicine ☐ Pollen ☐ Other		
12. Carry an epinephrine auto-injector?		
Breathing (Respiratory) Health	**No**	**Yes**
13. Ever complained of getting more tired or short of breath than his/her friends during exercise?	☐	☐
14. Wheeze or cough frequently during or after exercise?	☐	☐
15. Ever been told by a health care provider they have asthma?	☐	☐
16. Use or carry an inhaler or nebulizer?	☐	☐

Has/Does your child:

Concussion/ Head Injury History	No	Yes
17. Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told he/she had a concussion?	☐	☐
18. Ever had a head injury or concussion?	☐	☐
19. Ever had headaches with exercise?	☐	☐
20. Ever had any unexplained seizures?	☐	☐
21. Currently receive treatment for a seizure disorder or epilepsy?	☐	☐
Devices/Accommodations	**No**	**Yes**
22. Use a brace, orthotic, or other device?	☐	☐
23. Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)? If yes, there may be need for another required form to be filled out.	☐	☐
24. Wear protective eyewear, such as goggles or a face shield?	☐	☐
Family History	**No**	**Yes**
25. Have any relative who's been diagnosed with a heart condition, such as a murmur, developed hypertrophic cardiomyopathy, Marfan Syndrome, Brugada Syndrome, right ventricular cardiomyopathy, long QT or short QT syndrome, or catecholaminergic polymorphic ventricular tachycardia?	☐	☐
Females Only	**No**	**Yes**
26. Begun having her period?	☐	☐
27. Age periods began:		
28. Have regular periods?	☐	☐
29. Date of last menstrual period:		
Males Only	**No**	**Yes**
30. Have only one testicle?	☐	☐
31. Have groin pain or a bulge or hernia in the groin?	☐	☐

This sample resource was created by the NYS Center for School Health located at www.schoolhealthny.com –12/2020

Staten Island Academy
715 Todt Hill Road
Staten Island, NY 10304

Recommended NYSED Interval Health History for Athletics – Page 2

Student Name:

School Name: DOB:

Has/Does your child:

Heart Health	No	Yes
32. Ever passed out during or after exercise?	☐	☐
33. Ever complained of light headedness or dizziness during or after exercise?	☐	☐
34. Ever complained of chest pain, tightness or pressure during or after exercise?	☐	☐
35. Ever complained of fluttering in their chest, skipped beats, or their heart racing, or does he/she have a pacemaker?	☐	☐
36. Ever had a test by a health care provider for his/her heart (e.g. EKG, echocardiogram stress test)?	☐	☐
37. Ever been told they have a heart condition or problem by a health care provider? If so, check all that apply: ☐Heart infection ☐Heart Murmur ☐High Blood Pressure ☐Low Blood Pressure ☐High Cholesterol ☐Kawasaki Disease ☐Other:		

Injury History	No	Yes
38. Ever been diagnosed with a stress fracture?	☐	☐

Has/Does your child:

Injury History continued	No	Yes
39. Ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling?	☐	☐
40. Ever had an injury, pain, or swelling of joint that caused him/her to miss practice or a game?	☐	☐
41. Have a bone, muscle, or joint injury that bothers him/her?	☐	☐
42. Have joints become painful, swollen, warm, or red with use?	☐	☐
Skin Health	**No**	**Yes**
43. Currently have any rashes, pressure sores, or other skin problems?	☐	☐
44. Have had a herpes or MRSA skin infections?	☐	☐
Stomach Health	**No**	**Yes**
45. Ever become ill while exercising in hot weather?	☐	☐
46. Have a special diet or need to avoid certain foods?	☐	☐
47. Have to worry about his/her weight	☐	☐
48. Have stomach problems?	☐	☐
49. Ever had an eating disorder?	☐	☐

COVID-19 Information	No	Yes
50. Has your child ever tested positive for COVID-19?	☐	☐
51. Was your child symptomatic?	☐	☐
52. Did your child see a healthcare provider (HCP) for their COVID-19 symptoms?	☐	☐
53. 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 provide additional information.	☐	☐
54. Was your child hospitalized? If yes, 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 question you answered yes to in the space below, include dates if known.
Use additional pages if necessary.

Parent/Guardian Signature: _____ Date: