



## Rochester City School District

### PARENT'S CONSENT TO PUPIL PARTICIPATION IN CLUBS, GAMES AND COMPETITIVE SPORTS

School \_\_\_\_\_

Date \_\_\_\_\_

I \_\_\_\_\_ the parent/guardian of \_\_\_\_\_ hereby permit him/her to engage in club activities, after-school games, athletics and competitive sports, as conducted by the public schools and at my risk. If, at any time, I deem that the continuance of this permission is inadvisable, I must notify the school principal in writing. I have read the policy of the City School District concerning accidents printed below on this form and agree to allow my child to participate under these conditions.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Parent or Guardian Signature

The Dignity for All Students Act (Dignity Act) amended New York State Education Law by creating a new Article 2 – *Dignity for All Students*. The intent of the Dignity Act is to provide all public school students with an environment free from discrimination and harassment, including bullying, taunting or intimidation, as well as to foster civility in public schools.

#### **POLICY OF ROCHESTER CITY SCHOOL DISTRICT IN CASE OF ACCIDENTS TO PUPILS OCCURRING IN SCHOOL OR ON SCHOOL PROPERTY:**

- MINOR INJURIES.** Treatment of cuts, bruises, abrasions, etc., is in general rendered by the Community Health Nurse (C.H.N.) of the BOCES I School Health Services. In the absence of the nurse, treatment is rendered by the Health or Physical Education teacher, school staff or other available person.
- MAJOR INJURIES.** Send injured pupil to hospital nearest to the school by ambulance or taxi cab. Pending its arrival, first aid is rendered by C.H.N. or other available person.
- CONCUSSIONS:** New York State Law (Effective July 1, 2012) requires students who have suffered or are believed to have suffered a concussion to be removed from the activity immediately. Students are prohibited from returning to play until they have been without symptoms for 24 hours. Student-athletes must also obtain both written authorization from a doctor clearing them for activity and also approval from the school's medical director. After being symptom free for 24 hours and being released from a Physician's care, the student-athlete must successfully complete a 6-step Return to Play (RTP) protocol.
- TREATMENT AT HOSPITAL.** On arrival at the hospital, medical treatment is rendered by hospital staff. Supervision of the case by the City School District ceases.
- NOTIFICATION OF PARENTS.** Wherever possible, the parent is notified of an injury to a child, but necessary medical attention is not delayed on this account.
- PAYMENT FOR MEDICAL SERVICES IN CASE OF INJURY.** Every City School District student is covered by a School Accident Insurance Policy issued by Blue Cross/Blue Shield, which provides minimal coverage in case of injury. **NOTE** that in cases of injury, it is the parent's health coverage, if any, which must first be applied to cover medical costs. Only after the parent's health insurance benefits are exhausted does the School Accident Policy apply and then only up to the policy limits. Parents may be responsible for medical costs beyond the policy limits or which are not reimbursable under the School Accident Policy.

#### **POLICY OF ROCHESTER CITY SCHOOL DISTRICT CONSENT TO USE OF PHOTOGRAPHS AND IMAGES**

- All photographs taken of teams and individual athletes can be used for the school yearbook, school social media accounts and school advertisements.

*This parent permission form must be signed by the parent/guardian and the student and filed with the school athletic director. The athletic director then submits the student's name to the nurse for a physical.*

## ELIGIBILITY RULES

## YOU ARE ELIGIBLE:

1. If you are a bona fide student of the high school represented and taking at least four subjects including Physical Education;
2. If you are in grades 9-12 and under the age of 19. (If the age of 19 is reached on or after July 1, you may participate during that school year.) [Students in grades 7-8 may participate in the modified sports program or in the high school interscholastic program if they meet the requirement of the Selective/Classification process.];
3. If your parent/guardian approves, you have taken an athletic physical from a physician of your parent/guardian's choice or a physical offered by the City School District, and you receive final clearance through the school nurse;
4. If you enrolled during the first 15 school days of the semester;
5. Transfer: (a) A student who transfers, with a corresponding change in residence of his/her parents (or other persons with whom the student has resided for at least six months), shall become eligible after starting regular attendance in the second school. A residence change must involve a move from one school district to another. Furthermore, when a student moves from one public school district to another public school district, for athletic eligibility the student must enroll in the public school district of his/her parent's residency.  
(b) A student who transfers without a corresponding change in residence of his/her parents (or other persons with whom the student has resided for at least six months) is ineligible to participate in any interscholastic athletic contest in a particular sport for a period of one (1) year if the student participated in that sport during the one (1) year period immediately preceding his/her transfer;
6. For eight consecutive semesters, beginning with the semester in which you entered grade 9. [Under the Selective/Classification process, a student in grade 7 may be eligible for six consecutive seasons and a student in grade 8 may be eligible for five consecutive seasons in one sport.];
7. To participate on only one team during a sports season;
8. If you have not violated the all-star game rule restrictions of N.Y.S.P.H.S.A.A.;
9. If you have not practiced or played with a college team;
10. If you are an amateur, never having used your athletic skills for financial gain, and if you have never competed under an assumed name;
11. If you maintain a C average in all subjects, maintain a 90% daily class attendance, and demonstrate good citizenship;
12. No student shall be excluded from competition solely by gender. In the sports of baseball, basketball, field hockey, football, ice hockey, lacrosse, soccer, softball, power volleyball where the height of the net is set at less than eight feet and wrestling, the fitness of a given student to participate in mixed competition shall be determined by a review panel;
13. Students with handicapping conditions who are otherwise qualified are eligible to participate.

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Student Signature

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Parent or Guardian Signature

School Attending: \_\_\_\_\_  
 Desired Sport: \_\_\_\_\_  
 Desired Level: Modified Freshman JV Varsity

Rochester City School District  
 Interscholastic Athletics  
 Pre-Participation Form



|                                  |                                    |                             |            |
|----------------------------------|------------------------------------|-----------------------------|------------|
| Student Name: _____              | Gender: M F                        | Birthdate: _____            | Age: _____ |
| Name of Parent/Guardian: _____   | Phone Number: _____ Home Work Cell |                             |            |
| Name of Emergency Contact: _____ | Phone Number: _____ Home Work Cell |                             |            |
| Address & Zip: _____             | Grade: _____                       | Date Entered Grade 9: _____ |            |

**Completed by Parent/Guardian:** Answer the questions below completely and correctly, to the best of your knowledge.

- |  | Yes                      | No                       |  | Yes                      | No                       |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason?   | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have any ongoing medical concerns? If yes, please identify: <input type="checkbox"/> asthma <input type="checkbox"/> diabetes <input type="checkbox"/> life-threatening allergies <input type="checkbox"/> other: _____  | <input type="checkbox"/> | <input type="checkbox"/> | 14. Have you ever had any broken or fractured bones or dislocated joints?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever spent the night in the hospital?  | <input type="checkbox"/> | <input type="checkbox"/> | 15. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had surgery?  | <input type="checkbox"/> | <input type="checkbox"/> | 16. Have you ever had a stress fracture?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out or nearly passed out during or after exercise?   | <input type="checkbox"/> | <input type="checkbox"/> | 17. Do you regularly use a brace, orthotics, or other assistive device?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?   | <input type="checkbox"/> | <input type="checkbox"/> | 18. Do you have a bone, muscle, or joint that currently bothers you?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Does your heart ever race or skip beats (irregular beats) during exercise?  | <input type="checkbox"/> | <input type="checkbox"/> | 19. Do you cough, wheeze, or have difficulty breathing during or after exercise?                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Has a doctor ever told you that you have any heart problems? If yes, please identify: <input type="checkbox"/> high blood pressure <input type="checkbox"/> high cholesterol <input type="checkbox"/> a heart murmur <input type="checkbox"/> a heart infection <input type="checkbox"/> Kawasaki disease <input type="checkbox"/> other: _____ | <input type="checkbox"/> | <input type="checkbox"/> | 20. Have you ever used an inhaler or taken asthma medication?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Has a doctor ever ordered a test for your heart (i.e. ECG/EKG, echocardiogram)?   | <input type="checkbox"/> | <input type="checkbox"/> | 21. Were you born without or are you missing a kidney, an eye, a testicle, your spleen, or any other organ?            | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you get unbearably lightheaded or short of breath during exercise?  | <input type="checkbox"/> | <input type="checkbox"/> | 22. Have you had infectious mononucleosis (mono) within the last month?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 40?   | <input type="checkbox"/> | <input type="checkbox"/> | 23. Do you currently have any rashes, sores, or other skin problems?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Does anyone in your family have any heart problems?  | <input type="checkbox"/> | <input type="checkbox"/> | 24. Have you ever had a MRSA skin infection?   | <input type="checkbox"/> | <input type="checkbox"/> |
|  |                          |                          | 25. Have you ever had a head injury or concussion?   | <input type="checkbox"/> | <input type="checkbox"/> |
|  |                          |                          | 26. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?         | <input type="checkbox"/> | <input type="checkbox"/> |
|  |                          |                          | 27. Do you have a history of seizure disorder?   | <input type="checkbox"/> | <input type="checkbox"/> |
|  |                          |                          | 28. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?                 | <input type="checkbox"/> | <input type="checkbox"/> |
|  |                          |                          | 29. Have you ever become ill after while exercising in the heat?   | <input type="checkbox"/> | <input type="checkbox"/> |
|  |                          |                          | 30. Do you get frequent muscle cramps when exercising?   | <input type="checkbox"/> | <input type="checkbox"/> |
|  |                          |                          | 31. Do you sickle cell disease?  | <input type="checkbox"/> | <input type="checkbox"/> |
|  |                          |                          | 32. Have you had any problems with your vision or hearing?   | <input type="checkbox"/> | <input type="checkbox"/> |
|  |                          |                          | 33. Are you currently taking any medication?   | <input type="checkbox"/> | <input type="checkbox"/> |

*This certifies that, with the following requirements, the above student is qualified to participate in interscholastic athletics.*

**Completed by School Nurse:**

**Requirements:**

- glasses, contact lenses, or protective eyewear  
 asthma inhaler  diabetic supplies  epi-pen  
 other medical requirements: \_\_\_\_\_  
 \_\_\_\_\_  
 current prescriptions & OTC medications: \_\_\_\_\_  
 \_\_\_\_\_

|                                     |  |              |  |
|-------------------------------------|--|--------------|--|
| <b>Nurse Signature:</b>             |  | <b>Date:</b> |  |
| <b>Athletic Director Signature:</b> |  | <b>Date:</b> |  |

Name of Physician: \_\_\_\_\_

Name of Health Center: \_\_\_\_\_

Date of Last Physical: \_\_\_\_\_

*Females Only:*

Have you ever had a menstrual period? Yes No

If yes, at what age did you begin menstruating? \_\_\_\_\_

**Explain "Yes" answers below:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct, and therefore, I \_\_\_\_\_, have no reason to disallow \_\_\_\_\_ from participation in interscholastic athletics.  
 (name of parent/guardian) (name of student)

**Student Signature:** \_\_\_\_\_ **Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



## HEALTH APPRAISAL INFORMED CONSENT AND HISTORY FOR SCHOOL EXAMINATION

Education Law, Section 903, and the Regulations of the Commissioner of Education require physical examinations of all children when they:

- Enter the school district for the first time
- Are in grades Pre-K, K, 2, 4, 7, and 10
- Participate in interscholastic sports
- Need working papers
- Are referred to/by the Committee on Special Education
- Are deemed necessary by school authorities to determine a child's educational program

A dental examination by your private dentist is recommended on the same schedule as the grade mandated physical examinations. The school nurse can provide you with a list of reduced cost dental programs.

The Board of Education recommends that all medical and dental examinations be conducted by your private physician or other health care provider for privacy and continuity of care. The school nurse can assist you in securing insurance for children who do not have coverage, but who wish to have a private physician or other health care provider. However, in some instances, you may prefer to have the exam conducted in school. Please read the information below carefully and discuss the process and your decision with your child. Then please complete the permission form and the brief health questionnaire. Please do not ask the school to conduct the examination if your child is frightened and you cannot be present. Instead, contact the school nurse for assistance with other options to fulfill this legal mandate.

Although most parents do not attend examinations, you have a right to be present by prior arrangement with your school nurse. Your child will be asked age-appropriate psycho-social questions to assist the physician or nurse practitioner in targeting health risks. You may request a copy of sample questions from the school nurse. Please remember that efforts are made to question children uniformly, but based on children's responses, the exact list of questions may or may not be addressed and other follow up questions may be required.

Your child will be asked to disrobe to underclothing: boys will wear socks and underpants; girls will wear socks, underpants, and a loose shirt without a bra or undershirt. While every effort is made to preserve dignity and privacy, most health offices are too small to provide the level of privacy your child may be used to in his/her private provider's office. Other children of the same sex may be in the changing area. Your child may need to walk small distances partially clothed to get to, from, and around the exam area. The exam includes a complete head-to-toe screening of all major organ systems, INCLUDING BREASTS/PUBIC AREA FOR GIRLS AND HERNIA/PENIS/TESTICLES/PUBIC AREA FOR BOYS, AND INGUINAL/GROIN AREA FOR PULSE EXAMINATION FOR BOTH GENDERS. The examiner will touch your child. There may or may not be an additional person as a chaperone present during the examination. **THIS IS AN INTIMATE EXAM BEST DONE IN YOUR PRIVATE PHYSICIAN'S OFFICE BY A PROVIDER YOUR CHILD KNOWS AND TRUSTS.**

PLEASE ANSWER THE QUESTIONS ON THE REVERSE OF THIS PAGE AND SIGN YOUR CONSENT. AN EXAMINATION WILL NOT BE DONE IN SCHOOL WITHOUT YOUR SIGNED CONSENT. DELAYS IN RETURNING PERMISSION COULD RESULT IN A DELAY IN YOUR CHILD'S CLEARANCE FOR EXTRACURRICULAR ACTIVITIES INCLUDING SPORTS.

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_

My child had a health appraisal done by Dr. \_\_\_\_\_ on \_\_\_\_\_. I will provide the District with the Health Appraisal form, filled out by the doctor.

My child has an appointment to have a health examination done by Dr. \_\_\_\_\_ on \_\_\_\_\_. I will provide the District with the Health Appraisal form, filled out by the doctor when the examination is completed.

Please provide me with assistance to apply for Child Health Plus insurance so I can take my child to a private provider.

I give permission to have my child interviewed and examined by the school providers scheduled at the convenience of the school. I attest I have read the above information on health appraisals and have advised my child of my decision.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

PLEASE RETURN FORM TO YOUR SCHOOL NURSE

# Parent Permission for a School Examination

Student's Name \_\_\_\_\_

Grade \_\_\_\_\_ DOB \_\_\_\_\_ Teacher \_\_\_\_\_

Please answer the following questions. Circle or X the correct answer.

## HAS THE STUDENT EVER:

|   |    |     |
|---|----|-----|
| Had any serious injuries, illnesses or operations?.....   | No | Yes |
| Had any dizziness, fainting, or chest pain while exercising?.....   | No | Yes |
| Had asthma or other breathing problems?.....  | No | Yes |
| Had any heart problems or high blood pressure?.....   | No | Yes |
| Had a bleeding disorder?.....   | No | Yes |
| Had a liver or spleen problem?.....   | No | Yes |
| Had a hernia, undescended testicle or absence of one testicle?.....   | No | Yes |
| Had kidney disease or absence of one kidney?.....   | No | Yes |
| Had any muscle, joint, or bone problems, including fractures?.....  | No | Yes |
| Been knocked unconscious, or had a concussion?.....   | No | Yes |
| Had seizures? No Yes If yes, are they well controlled?.....   | No | Yes |
| Does your child have any current skin problem, sores, or rashes?.....   | No | Yes |
| Are there any life threatening allergies?.....  | No | Yes |
| Does your child have any other life threatening condition?.....   | No | Yes |
| Is the student currently taking any medication?.....  | No | Yes |
| Are medications needed for the sport? No Yes Will child carry medicine?....   | No | Yes |
| Does your child have absence of vision in one eye or loss of an eye?.....   | No | Yes |
| Does your child wear glasses or contact lenses?.....  | No | Yes |
| Does your child have hearing impairment in <input type="checkbox"/> one <input type="checkbox"/> both ears?.....  | No | Yes |
| Does your child wear orthodontic equipment (braces, retainer, etc.)?.....   | No | Yes |
| Are you aware of any medical or physical restrictions which might disqualify<br>or limit your child's full participation in any of our athletic programs? ..... | No | Yes |
| For Girls: Are there any problems regarding menstruation?.....  | No | Yes |
| Date or age when menstruation began _____   |    |     |

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IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE EXPLAIN ON SEPARATE PAGE.

I have read/heard and understand what is involved in a school physical examination for my child. I understand my child will be questioned about high risk behaviors, will need to disrobe, and further that parts of the exam may include breasts and genitalia, and education on self-examination. I have also answered all questions about his/her health history. I give permission to have my child interviewed and examined by the school physician/nurse practitioner at the convenience of the District. I will advise my child of my decision and will advise the school nurse if I want to be present during the examination.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Nurse's Signature: \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature: \_\_\_\_\_ required for verbal permission