

**RYE NECK UFSD EMERGENCY INFORMATION FORM**

*This form must be filled out in full by both the parent/legal guardian and student EVERY season and then brought to the nurse prior to the start of participation in practice.*

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Grade \_\_\_\_\_ Birth Date \_\_\_\_\_ Sport \_\_\_\_\_

Address \_\_\_\_\_ Home # \_\_\_\_\_

Parent's/Guardian's Name \_\_\_\_\_ Work/Cell # \_\_\_\_\_

Parent's/Guardian's Name \_\_\_\_\_ Work/Cell # \_\_\_\_\_

Parent's Email Address: \_\_\_\_\_

Date of Recent Physical \_\_\_\_\_ Doctor's Name \_\_\_\_\_ Phone \_\_\_\_\_

Medical Concerns (allergies, conditions, medications, etc): \_\_\_\_\_

Emergency Contact (other than parent or guardian) \_\_\_\_\_

Emergency Contact:  
Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**PERMISSION TO PARTICIPATE AND PROVIDE MEDICAL TREATMENT**

I HEREBY give permission for my son/daughter to participate in Rye Neck Union Free School District's interscholastic athletic programs and travel with the team, understanding that my child may suffer an injury or illness, which may put life or limb at risk, AND I give permission for the medical staff to provide proper treatment for my son/daughter that is within their training. By signing this form you pledge that you have reviewed the above information, found it to be correct, and approve of the agreement at the date below:

Student's Signature \_\_\_\_\_ Date \_\_\_\_\_ Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Do NOT FILL OUT BELOW THIS LINE**

\*\*\* Fill Out Form B \*\*\*

**RYE NECK UNION FREE SCHOOL DISTRICT EMERGENCY INFORMATION FORM**

*The following information is for Rye Neck Union Free School District Medical Staff Only. Please do not fill out any information below.*

Participation Level, circle:      Full Program                      Restricted Program                      No Program

Restrictions: \_\_\_\_\_

Other Medical Concerns: \_\_\_\_\_

**VERIFICATION BY SCHOOL NURSE**

This certifies that this student-athlete has a valid physical examination on file and is eligible for sport participation.

School Nurse \_\_\_\_\_

Date of Physical \_\_\_\_\_

**RYE NECK UFSD SEASONAL SPORTS UPDATE**

This evaluation is to determine readiness for sports participation. The form must be completed by both the parent and student before each season and brought to the nurse. If you need additional space please use the back of this form or attach another sheet.

Last, First Name \_\_\_\_\_ Grade \_\_\_\_\_ Sport \_\_\_\_\_

Address \_\_\_\_\_ Home # \_\_\_\_\_

Parent's/Guardian's Name \_\_\_\_\_ Work/Cell # \_\_\_\_\_

Parent's/Guardian's Name \_\_\_\_\_ Work/Cell # \_\_\_\_\_

Emergency Contact (other than parent or guardian) \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

**Medical History**

1. Date of most recent physical: \_\_\_\_\_

2. Do you have any allergies? If yes, list \_\_\_\_\_ no

3. Are you currently taking any drugs or medications including protein supplements? no

If yes, list \_\_\_\_\_

4. Are you presently being treated for any condition by a physician or health care professional? no

If yes, explain \_\_\_\_\_

5. Do you have any chronic conditions, disorders or diseases? Check those that apply or ..... no

Asthma  Bleeding Disorders  Diabetes  Epilepsy (Seizures)  Mononucleosis

Explain those checked \_\_\_\_\_

6. Please check where applicable if you have or have had any of the following:

	Yes	No		Yes	No
Head injury, concussion, or unconscious	<input type="checkbox"/>	<input type="checkbox"/>	Eye injury or retinal detachment	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how many times _____			Blurred vision or vision in one eye only	<input type="checkbox"/>	<input type="checkbox"/>
and most recent (date) _____			Wear glasses or contact lenses	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss/impairment in one or both ears	<input type="checkbox"/>	<input type="checkbox"/>
Lack of feeling in any part of the body	<input type="checkbox"/>	<input type="checkbox"/>	False teeth, caps or braces	<input type="checkbox"/>	<input type="checkbox"/>
Heat exhaustion or heat stroke	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease or dark brown/bloody urine	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain, dizziness, passing out during exercise	<input type="checkbox"/>	<input type="checkbox"/>	Less than: two kidneys	<input type="checkbox"/>	<input type="checkbox"/>
Smoke cigarettes or chew tobacco	<input type="checkbox"/>	<input type="checkbox"/>	Neck, spine, or low back injury or pain	<input type="checkbox"/>	<input type="checkbox"/>
Heart problem, murmur or arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>	For males: Less than two testicles	<input type="checkbox"/>	<input type="checkbox"/>
Family member with a heart attack under age 50	<input type="checkbox"/>	<input type="checkbox"/>	For females:		
Loss or gain of more than 10 lbs. in last year	<input type="checkbox"/>	<input type="checkbox"/>	Absent or irregular monthly periods	<input type="checkbox"/>	<input type="checkbox"/>
Special diet for medical reasons	<input type="checkbox"/>	<input type="checkbox"/>	Disabling cramps with menstrual periods	<input type="checkbox"/>	<input type="checkbox"/>

7. Have you ever been hospitalized for medical/surgical reasons? If yes, provide the following information:

Reason	Date	Hospital	no <input type="checkbox"/>
_____	_____	_____	
_____	_____	_____	

8. Please list below any injury (nerve, muscle, bone or joint) that you have had which did not allow you to participate in regular activity for a week or more. Attach another sheet if necessary.

Injured Area	Year	Side	Type	Resolved
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

9. Permission to Participate/Medical Treatment: I HEREBY give permission for my son/daughter to participate in Rye Neck Union Free School District's interscholastic athletic programs and travel with the team, understanding that my child may suffer an injury or illness, which may put life or limb at risk, AND I give permission for the medical staff to provide proper treatment for my son/daughter that is within their training. By signing this form you pledge that you have reviewed the above information, found it to be correct, and approve of the agreement at the date below

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

\*\*\*Return to School Nurse\*\*\*