YESHIVA UNIVERSITY HIGH SCHOOL FOR GIRLS

CENTRAL

ESTABLISHED 1948

SPECIAL REQUIREMENTS FOR INTERSCHOLASTIC ATHLETIC PARTICIPATION

PLEASE REVIEW CAREFULLY

Competitive athletics requires vigorous exercise and training. To ascertain the health and ability of the student, NYS requires an annual sports-oriented evaluation. All athletes must have on file, in school, an updated Student Health History & Emergency Information Form and a current **Child and Adolescent Health Examination Form and the additional forms that follow below, no later than August 1, 2018:**

We ask you to review **Central's Policy on Protecting Athletes** and other athletic-specific information, which can be found on our school website by clicking the Athletics link - **yuhsg.org/student-life/athletics/**

** Central is NOT responsible for any claims due to injuries, damage, or death due to participation in athletics. It is the sole responsibility of each parent/guardian to maintain an active health insurance plan that will cover the student's injuries sustained in such activities. All claims for benefits because of injuries suffered in the play or practice of athletics MUST be submitted to the student's insurance company for payment. It is important that the parent/guardian check with the student's insurance carrier to insure that she is covered for these injuries.

2018-2019 Central/Yeshiva University High School for Girls

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly Press Hard

STUDENT ID NUMBER OSIS

TO BE COMPLETED BY PARENT OR GUARDIAN

Child's Last Name | First Name | Middle Name | **Sex** ☐ Female ☐ Male | **Date of Birth** *(Month/Day/Year)* __ __ / __ __ / __ __ __ __

Child's Address | **Hispanic/Latino?** ☐ Yes ☐ No | **Race** *(Check ALL that apply)* ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other _____

City/Borough | State | Zip Code | School/Center/Camp Name | District Number __ __ __ | **Phone Numbers** *Home* _____ *Cell* _____ *Work* _____

Health insurance (including Medicaid)? ☐ Yes ☐ No | ☐ **Parent/Guardian** Last Name | First Name | ☐ **Foster Parent**

TO BE COMPLETED BY HEALTH CARE PROVIDER *If "yes" to any item, please explain (attach addendum, if needed)*

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* _____

☐ Foods *(list)* _____

☐ Other *(list)* _____

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma *(check severity and attach MAF/Asthma Action Plan):* ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Inhaled corticosteriod ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None

☐ Attention Deficit Hyperactivity Disorder
☐ Chronic or recurrent otitis media
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes *(attach MAF)*
☐ Orthopedic injury/disability
☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ **Other** *(specify)* _____

Explain all checked items above or on addendum

Medications *(attach MAF if in-school medication needed)*

☐ None ☐ Yes *(list below)*

Dietary Restrictions

☐ None ☐ Yes *(list below)*

PHYSICAL EXAMINATION

Height _____ **cm** (__ __ %ile)

Weight _____ **kg** (__ __ %ile)

BMI _____ **kg/m²** (__ __ %ile)

Head Circumference *(age ≤2 yrs)* _____ **cm** (__ __ %ile)

Blood Pressure *(age ≥3 yrs)* _____ / _____

General Appearance:

	NI	Abnl		NI	Abnl		NI	Abnl		NI	Abnl		NI	Abnl
HEENT	☐	☐	Lymph nodes	☐	☐	Abdomen	☐	☐	Skin	☐	☐	Psychosocial Development	☐	☐
Dental	☐	☐	Lungs	☐	☐	Genitourinary	☐	☐	Neurological	☐	☐	Language	☐	☐
Neck	☐	☐	Cardiovascular	☐	☐	Extremities	☐	☐	Back/spine	☐	☐	Behavioral	☐	☐

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)* ☐ Within normal limits

If delay suspected, specify below

☐ Cognitive *(e.g., play skills)* _____

☐ Communication/Language _____

☐ Social/Emotional _____

☐ Adaptive/Self-Help _____

☐ Motor _____

SCREENING TESTS	Date Done	Results
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	__/__/__	_____ µg/dL
	__/__/__	_____ µg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	__/__/__	☐ At risk *(do BLL)* ☐ Not at risk
Hearing ☐ Pure tone audiometry ☐ OAE	__/__/__	☐ Normal ☐ Abnormal
Head Start Only		
Hemoglobin or Hematocrit *(age 9–12 mo)*	__/__/__	_____ g/dL _____ %

	Date Done	Results
Tuberculosis *Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school*		
PPD/Mantoux *placed*	__/__/__	Induration _____mm
PPD/Mantoux *read*	__/__/__	☐ Neg ☐ Pos
Interferon Test	__/__/__	☐ Neg ☐ Pos
Chest x-ray *(if PPD or Interferon positive)*	__/__/__	☐ NI ☐ Abnl ☐ Not Indicated
Vision *(required for new school entrants and children age 4–7 yrs)*	__/__/__ ☐ with glasses	Acuity *Right* ___/___ *Left* ___/___ Strabismus ☐ No ☐ Yes

IMMUNIZATIONS – DATES

CIR Number of Child

Hep B	__/__/__	__/__/__	__/__/__	__/__/__
Rotavirus	__/__/__	__/__/__	__/__/__	
DTP/DTaP/DT	__/__/__	__/__/__	__/__/__	__/__/__
	__/__/__	__/__/__	__/__/__	__/__/__
Hib	__/__/__	__/__/__	__/__/__	
PCV	__/__/__	__/__/__	__/__/__	__/__/__
Polio	__/__/__	__/__/__	__/__/__	

Influenza	__/__/__	__/__/__	__/__/__	__/__/__
MMR	__/__/__	__/__/__	__/__/__	__/__/__
Varicella	__/__/__	__/__/__		
Td	__/__/__	__/__/__	__/__/__	__/__/__
Tdap __/__/__	Hep A	__/__/__	__/__/__	
Meningococcal	__/__/__	__/__/__		
HPV	__/__/__	__/__/__	__/__/__	
Other, *specify:* _____	__/__/__	; _____		__/__/__

RECOMMENDATIONS ☐ Full physical activity ☐ Full diet

☐ Restrictions *(specify)* _____

Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: __/__/__

Referral(s): ☐ None ☐ Early Intervention ☐ Special Education ☐ Dental ☐ Vision

☐ Other _____

ASSESSMENT ☐ **Well Child** (V20.2) ☐ **Diagnoses/Problems** *(list)* **ICD-9 Code**

_____ __ __ __ __

_____ __ __ __ __

_____ __ __ __ __

Health Care Provider Signature | Date __ __ / __ __ / __ __

Health Care Provider Name and Degree *(print)* | Provider License No. and State

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone (__ __ __) __ __ __ – __ __ __ __ | Fax (__ __ __) __ __ __ – __ __ __ __

DOHMH ONLY **PROVIDER I.D.**

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments

Date Reviewed: __/__/__ I.D. NUMBER

REVIEWER:

CH-205 (5/08)

Copies: **White** School/Child Care/Early Intervention/Camp, **Canary** Health Care Provider, **Pink** Parent/Guardian

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Yeshiva University High School for Girls
86-86 Palo Alto Street
Holliswood, NY 11423
Phone: (718) 479-8550 Fax: (718) 479-8686

****To be completed and signed by the student and her parent/guardian****

INTERSCHOLASTIC ATHLETIC PARTICIPATION CONSENT FORM 2018/19

- **Participation in interscholastic athletics is voluntary and is not a required part of the regular physical education program.**
- **This form must be completed, signed, and returned before the athlete can try out for interscholastic sports.**

Student Name (please print)_____Grade_____

_____Date of Birth_____

Do you have any concerns about your child's health or other questions in regards to participation in the Athletics program?
• NO • YES If yes, please explain below: _____

I give my daughter permission to participate on the following interscholastic teams (please cross off any interscholastic teams you wish to exclude):

Basketball Volleyball Floor Hockey Soccer Softball Tennis

- I agree with the above answers and consent to the participation of my child in the interscholastic athletic program including tryouts, practice sessions, athletic contests and travel to and from the athletic contests.
- I agree to submit all required documentation, including the Child & Adolescent Health Examination Form and the YUHSG Interscholastic Athletics Health Examination Form, completed, signed and stamped by my daughter's healthcare provider.
- I agree to update the school health coordinator should any information change in my daughter's health history.
- I have completed, signed, and returned the YUHSG Emergency & Illness Information card, prior to the submission of this form or accompanying the submission of the Student Health History Form.
- I have completed, signed, and returned the Student-Athlete Insurance Form. I acknowledge and agree that YUHSG is NOT responsible for any claims due to injuries, damage or death due to participation in athletics. I fully understand that it is my sole responsibility to maintain an active health insurance plan that will cover my daughter's injuries sustained in such activities; and that any claims for benefits because of injuries suffered in the play or practice of athletics MUST be submitted to my daughter's insurance company for payment. I have confirmed with my daughter's insurance carrier that she is covered for these injuries.
- I understand that athletic activity involves the potential for injury which is inherent in all sports. In consideration of my daughter being allowed to participate in interscholastic athletics, and intending to be legally bound, I (for myself and my daughter) do hereby release and forever discharge Yeshiva University High School for Girls and its affiliates and related entities, and their respective employees and agents, from any/all actions or suits in law or equity which I/we may hereafter have, by reason of injuries sustained by my daughter while participating in interscholastic sports, including in transit to or from participation in interscholastic sports.

I have read and reviewed the **YUHSG Student-Athlete Handbook** as well as the **Parent/Athlete Concussion Information Sheet**.

Parent/Guardian Name_____Signature _____Date _____

Student/Athlete Name_____Signature _____Date _____

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****To be completed and signed by the student's healthcare provider****

INTERSCHOLASTIC ATHLETIC HEALTH EXAMINATION FORM 2018-2019

This certifies that _____in Grade _____ is physically qualified to participate in the following athletic practices and competitions during the 2018-2019 school year, **except those crossed out below:**

Basketball **Volleyball** **Floor Hockey** **Soccer** **Softball** **Tennis**

Date of student's last complete health examination: _____

Healthcare Provider's Name: _____

Address: _____

City/State/Zip _____

Phone: (____)_____

Healthcare Provider's Signature: _____ Date: _____

Healthcare Provider's Stamp:

If your daughter has asthma, anaphylaxis allergies, diabetes or other medical conditions requiring medication in school, please be sure to complete the appropriate **Medication Administration Form(s) (MAF).** Any student with these conditions must have their health care provider complete and sign the appropriate forms linked below:

- **Allergy/Anaphylaxis MAF,**
- **Asthma MAF,**
- **Diabetes MAF,**
- **Non-Asthma/Non-Allergy MAF**.
- **Self-Medication Release Form**

Other medications should also be listed on the **Child and Adolescent Health Examination Form.**

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2018-2019 Student-Athlete Insurance Information Form

PLEASE PRINT ALL INFORMATION REQUESTED ON THIS FORM IN BLACK INK ONLY.

All information will be kept confidential and used solely for the purpose of providing appropriate medical care for the student-athlete.

Student-Athlete Name _____Date of Birth_____
ALLERGIES_____
Home Address_____City_____State_____Zip_____
Home Phone (Area Code)_____
Mother/Guardian Name_____Work Phone_____Cell Phone_____
Address (if other than above)_____City_____State_____Zip_____
Father/Guardian Name_____Work Phone_____Cell Phone_____
Address (if other than above)_____City_____State_____Zip_____

PRIMARY INSURANCE INFORMATION - *PLEASE ATTACH A COPY OF BOTH SIDES OF YOUR INSURANCE CARD*

Policy Holder's Name_____Policy Holder's Home Phone_____
Policy Holder's Date of Birth_____Policy Holder's Cell Phone _____
Policy Holder's Employer_____
Employer's Address_____City_____State_____Zip_____
Insurance Company_____Customer Service Phone_____
Insurance Company Claims Address_____ City_____State_____Zip_____
Group Number_____ID/Member Number_____Other Number_____
Insurance Type (please circle) HMO PPO POS UNRESTRICTED If policy is an HMO, is guest coverage available? YES NO
Primary Care Physician (PCP) _____ Phone_____
Does your policy cover athletic related injuries? YES NO Is a referral required from your PCP to see a specialist? YES NO

SECONDARY INSURANCE INFORMATION (If Applicable)

Policy Holder's Name_____Policy Holder's Home Phone_____
Policy Holder's Date of Birth_____Policy Holder's Cell Phone _____
Policy Holder's Employer_____
Employer's Address_____City_____State_____Zip_____
Insurance Company_____Customer Service Phone_____
Insurance Company Claims Address_____ City_____State_____Zip_____
Group Number_____ID/Member Number_____Other Number_____
Insurance Type (please circle) HMO PPO POS UNRESTRICTED If policy is an HMO, is guest coverage available? YES NO
Primary Care Physician (PCP)_____Phone_____
Does your policy cover athletic related injuries? YES NO Is a referral required from your PCP to see a specialist? YES NO

I hereby certify that the answers provided are true, complete and correct to the best of my knowledge. I understand that my daughter must carry an insurance policy that will remain in force and cover claims for injuries incurred while participating in athletic practice or games. ***I also understand that Samuel H. Wang Yeshiva University High School for Girls will not be responsible for payment of such claims.***

SIGNATURE OF POLICY HOLDER_____ DATE_____