CITY SCHOOL DISTRICT OF ALBANY
BUREAU OF HEALTH AND PHYSICAL EDUCATION

HEALTH HISTORY AND REGISTRATION

GREEN TECH CHARTER HIGH SCHOOL	____________	____________
SCHOOL	DATE	GRADE ENTERING

The information you provide on this form will become part of your child's Permanent Health Record. To protect your child and to help the District to appropriately respond to the health needs of your child, please answer all questions on **BOTH** sides of the form.

A certificate of immunization must be attached to this registration.

Child's Name (Last, First) ____________ Sex ______ Date of Birth ____________

Child's Address (No. and Street - Apt. No. - Zip Code) ____________ Telephone Number/s ____________

Father/Guardian ____________ Mother/Guardian ____________

Father/Guardian's Home and Work Telephone Nos. ____________ Mother/Guardian's Home and Work Telephone Nos. ____________

Emergency Contact #1 (Name, Relationship and Telephone Nos.) ____________

Emergency Contact #2 (Name, Relationship and Telephone Nos.) ____________

School Last Attended ____________ Albany Public Schools Attended ____________

Health Care Provider ____________ Approximate Date of Last Physical Examination ____________

Dentist ____________ Approximate Date of Last Dental Examination ____________

Insurance Information: Health Plan ____________ ID/CIN # ____________ Group # ______

BROTHERS AND SISTERS:

Name	Date of Birth	Grade/School

Note: For the safety and wellbeing of your child, you must be accessible in the event of illness or injury. Notify the school immediately if any of the emergency numbers or contacts you provided above change. It is not in the best interest of an ill or injured child to be maintained indefinitely at school. Parents must pick up their child when the child is ill or injured. If parents are unable to do so, they must designate a responsible adult to pick up and attend to their child.

OVER →

If your child has had any of the following health problems or diseases, please check below and provide details in the comment column.

HEALTH HISTORY				**COMMENT** Please use this space to provide details for any condition/s checked.
Blood Disorders		Allergies		
Chicken Pox		Asthma		
Chronic Ear Infections		Birth Defects		
Hearing Loss		Bone/Joint Muscle Problems		
Hepatitis		Diabetes		
Mono		Heart Disease or Murmur		
Scarlet Fever/Strep		Lead Level Elevated		
Sickle Cell Disease		Operations/Hospitalizations		
Speech Problems		Seizure Disorders		
Tuberculosis		Serious Injuries		
Vision Problems		Other Health Issues		

Were there any complications during the pregnancy of this child? _______. If so, please describe. ________

____.

What was the length of the pregnancy? _____ What was your child's birth weight? _______

Were there any complications during the birth of this child? ________. If so, please describe. ______________

____.

Does your child take any regular medications? If so, please list. ____________________________________

____.

Does your child have any social or emotional problems that may impact his/her ability to learn and socialize in school?

___________. If so, please explain. ____

____.

New York State Education Law requires <u>all new</u> entrants and students in Pre-K or K, 1,3,5,7,<u>9</u> and <u>11th</u> grades to have a physical exam. If a physical form is not returned to school before our school physicians come for physicals, your child will have a health appraisal in school.

Your signature authorizes health office personnel to share health related information with appropriate school staff when that information is necessary to insure the health and safety of your child.

____
Parent/Guardian Name

______________________________________ ______________________________
Parent/Guardian Signature Date

CITY SCHOOL DISTRICT OF ALBANY
BUREAU OF HEALTH AND PHYSICAL EDUCATION

SCHOOL HEALTH SERVICES
INFORMATION FOR PARENTS OR GUARDIANS

The following information pertains to New York State regulations and City School District of Albany policies governing School Health Services.

IMMUNIZATION

Communicable disease control is a primary responsibility of school and public health authorities. Mandatory immunization is one aspect of a comprehensive communicable disease control program.

> *New York State Public Health Law, Section 2164 mandates that schools not permit a child to be admitted unless the parent/guardian provides the school with a certificate of immunization or proof from a physician that the child is in the process of receiving the required immunizations.*

The required immunizations for school attendance are:

3 doses of diphtheria toxoid (usually administered as DPT, DTaP, or DPT/Hib)

3 doses of pertussis and tetanus vaccine (usually administered as DPT, DTaP, or DPT/Hib) for students born after January 1, 2005

1 booster containing diphtheria, tetanus, and acellular pertussis vaccine (Tdap) for children born on/after January 1, 1994 and entering sixth grade or a comparable special education program with an unassigned grade after September 1, 2007

3 doses of oral polio vaccine (OPV) or three doses of enhanced inactivated poliomyelitis vaccine (EIPV or more recently IPV*). **Note: "IPV" administered in the USA after 1988 is presumed to be EIPV.*

2 doses of measles vaccine, the first administered no more than 4 days before the first birthday, and the second no less than 28 days after the first

1 dose of rubella vaccine administered no more than 4 days before the first birthday

1 dose of mumps vaccine administered no more than 4 days before the first birthday

3 doses of haemophilus influenzae type b conjugate vaccine if given before 15 months of age or 1 dose if administered on or after 15 months of age for students entering preschool

3 doses of Hepatitis B vaccine for all children born after January 1, 1993 (includes Head Start, nursery, daycare)

3 doses of Hepatitis B vaccine for students enrolled in grade 7 on or after September 1, 2000. Children 11-15 years old may receive 2 doses of adult Hepatitis B to fulfill this requirement

1 dose of Varicella vaccine for children born on or after January 1, 1998 and entering kindergarten

1 dose of Varicella vaccine for children born on or after January 1, 2000 before enrollment in any school

1 dose of Varicella vaccine for children born on or after January 1, 1994 who enroll/are enrolled in grade six or a comparable special education program with an unassigned grade in September 2005

1 dose of Varicella vaccine for students born on or after January 1, 1994, and who transfer from another state or country and enter grade six after January 1, 2005

All of the above immunizations must be documented by your physician or the Health Department where the child received the immunizations, or must be from an official copy of the immunization record from the child's previous school.

A student may be exempt from any or all immunizations if a physician licensed to practice medicine in New York State certifies that such immunization/s may be detrimental to the child's health. This exemption is applicable until such immunization is found no longer to be detrimental to the child's health. The physician's certificate of exemption must indicate the medical condition or reasons that the specified immunizations might be detrimental to the child's health and the length of time for which the exemption must be in effect.

No certificate of immunization shall be required as a prerequisite to attending school for children whose parents/guardians hold genuine and sincere religious beliefs that are contrary to the practice of immunization. Such parents/guardians shall submit a written statement that must provide the name, address and phone number of their religious leader or advisor and an explanation of the specific belief that is contrary to the practice of immunization.

HEALTH APPRAISALS

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

- Enter a school district for the first time
- Are in grades Pre-K or K, 1,3,5,7,9, and 11th grade
- Participate in interscholastic sports
- Need working papers
- Are referred to the Committee on Special Education
- Require an appraisal deemed necessary by school authorities to determine an appropriate educational program for the individual

If a report of a child's examination is submitted from a primary health care provider, it must be signed by a physician, a nurse practitioner or physician's assistant working in collaboration with the physician. Submitted reports of examinations must describe the condition of the student when the examination was given and must state whether such student is in a fit condition of bodily health to permit his/her attendance.

The physical appraisal must be no more than twelve months prior to the commencement of the school year in which the examination is required.

Students must have a physical prior to participation in interscholastic sports.

DENTAL CERTIFICATES

Amendments to Education Law (Section 903) and Regulations of the Commissioner of Education require school districts to request dental certificates for children when they enter school for the first time and in grades Pre-K or K, 1,3,5,7, 9.and 11th grade. Dental health certificates must contain a report of a comprehensive dental examination and be signed by a dentist licensed to practice in New York State.

MEDICATION

School personnel are often asked to give medicine to children during school hours. Many medicines can be taken effectively outside school hours. If your doctor feels it is necessary for medication to be administered in school, contact the School Health Office to obtain a "Medication Permission" form. To administer medication to students in school the following steps must be taken for both prescription and over the counter medications.

1. Submit a written order to administer medication in school from your child's physician. The pharmacy label does not constitute a written order and cannot be used in lieu of a written order from a licensed physician. Faxed orders from licensed physicians are acceptable. Verbal permissions from the physician to administer medication are not acceptable.
2. Submit your written request that medication be administered to your child in school as ordered by his/her physician.

3. Deliver your child's medication directly to the Health Office in the original, properly labeled container.

Medications should not be transported daily to and from school. Parents/guardians should ask the pharmacist for two containers, one to remain at home and one at school. Medications must not be transported to school by students on school buses. This presents a danger to all students. Students may not carry medication on their person during the school day.

MEDICAL EXCUSE - PHYSICAL EDUCATION

It is the responsibility of the parent/guardian to keep the school informed of any health condition that would affect their child's safety, school performance, or toleration of physical activity. If for any reason a child is unable to participate in the physical education program, the parent/guardian must provide appropriate documentation from the attending physician indicating the problem, the specific limitations and the duration of those limitations. If a child is to be excused from the regular physical education program for more than two weeks, the parent/guardian must obtain information from the attending physician regarding the student's ability to participate in an adaptive physical education program.

HEALTH PROBLEMS

It is the responsibility of the parent/guardian to inform the school of any contagious diseases or unusual health problems that the child may have. In this way the school can plan for the child's safety and special needs in order to maximize the child's educational experience.

SCREENING

Vision screening is provided for new entrants and students in grades pre-K or K,1,3,5,7,9 and 11th. Hearing screening is provided for new entrants and students in grades Pre-K or K, 1, 3, 5,7,9, and 11th. Height, weight, and body mass index screening are conducted with new entrants and students in grades Pre-K or K, 1,3,5,7,9, and 11th. Parents/Guardians will be notified ONLY if problems are identified.

BODY MASS INDEX (BMI) SURVEY

Each year, a sample of schools in New York State are required to participate in a Department of Health survey to collect data on BMI and students' weight status category. Only summary information is included in the survey. No names or identifying information about individual students are shared. Parents/Guardians must notify the School Nurse in the school their child attends if they choose to have their child's BMI information excluded from the survey report.

EMERGENCY CONTACT

In the event a child is sick or injured in school, it is essential that the school have telephone numbers where a parent or responsible adult can be contacted. If the emergency contacts should change during the school year, parents/guardians MUST notify the school immediately and provide accurate, working phone numbers where a responsible party may be reached.

HEALTH NEEDS

The emotional as well as physical needs of each child are the concern of the School Health Services personnel. Parents/guardians should contact the School Nurse with information regarding the health needs of their child and to obtain information regarding available community health services that could respond to the needs of the child or family.

GREEN TECH HIGH SCHOOL HEALTH OFFICE

Health Office Phone (518) 407-2552 Fax (518) 434-0597
Email: nurse@greentechhigh.org
Main Office Phone (518) 694-3400 Fax (518) 694-3401

Dear Parents/Guardians,

New York State Education Law now requires students to have a physical examination when they:

- Are in **new** and in **grades 9 and 11.**
- **Participate in interscholastic sports**
- **Need working papers**
- Are referred to the Committee on Special Education or are scheduled for a triennial review
- Require an appraisal deemed necessary by school authorities to determine an appropriate educational program

In addition, the state has created a new form to reflect changes to the law. Health-care providers must enter the results of a health physical on a form called the New York State Education Department Student Health Examination Form for School.

Starting in 2019-20, only the updated form will be accepted.

The physical appraisal must describe the condition of the student when the examination was made, which may be no more than twelve months prior to the start of the school year in which the examination is required.

This must be provided to school with 30 days from when your child first starts school.

If the appraisal is for participation in interscholastic sports, it must be completed no more than 12 months prior to the first day of practice/tryouts for the selected sport.

If this form is not completed and returned to school, or if students do not receive physicals from private physicians, health appraisals will be provided by the school physician during the course of the school year.

Dental certificates are requested when student are new and in grades 9 and 11 as well.

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION

Name:	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type | ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached | ☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No ☐ Yes, indicate type | ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached | ☐ Intermittent ☐ Persistent ☐ Other : ____________________

Seizures ☐ No ☐ Yes, indicate type | ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached | ☐ Type:____________________ Date of last seizure: ______________

Diabetes ☐ No ☐ Yes, indicate type | ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached | ☐ Type 1 ☐ Type 2 ☐ HgbA1c results:____________ Date Drawn: ____________

Risk Factors for Diabetes or Pre-Diabetes:

Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother; and/or pre-diabetes.

BMI__________kg/m2 **Percentile (Weight Status Category):** ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and<

Hyperlipidemia: ☐ No ☐ Yes **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

TESTS	**Positive**	**Negative**	**Date**	**Other Pertinent Medical Concerns**
PPD/ PRN	☐	☐		One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
Sickle Cell Screen/PRN	☐	☐		☐ Concussion – Last Occurrence: ____________________
Lead Level Required Grades Pre- K & K			**Date**	☐ Mental Health: ____________________
☐ Test Done ☐ Lead Elevated ≥10 μg/dL				☐ Other:

☐ **System Review and Exam Entirely Normal**

Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

Diagnoses/Problems (list)	ICD-10 Code
____________________	__________
____________________	__________
____________________	__________
	__________

☐ Additional Information Attached

Name:				DOB:
SCREENINGS				
Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right** dB	**Left** dB	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No	
Deviation Degree:		Trunk Rotation Angle:		

Recommendations:

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications

- ☐ **No Contact Sports** — **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling
- ☐ **No Non-Contact Sports** — **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field
- ☐ **Other Restrictions:**

☐ **Developmental Stage for Athletic Placement Process ONLY**

Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports

Student is at **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Accommodations:** Use additional space below to explain

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ Other:

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: ____________________

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School attached**

List medications taken at home:		

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature:	**Date:**
Provider Name: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

Please Return This Form To Your Child's School When Entirely Completed.

GREEN TECH HIGH SCHOOL

Dear Parent or Guardian:

Poor dental health can cause pain, lead to significant life-long health problems, and can be a barrier to academic achievement.

New York State Law requires school districts to request Dental Certificates for students when they enter school and in **grades Pre-K, K, 1, 3, 5, 7, 9 and 11**.

Please take this form to your child's dental care provider to be completed. The dental assessment may be completed during or 12 months prior to the school year in which it is required.

Please return the completed form to your School Nurse. The results will be maintained in the permanent health record.

If you have questions or do not have a dental care provider for your child, please contact the School Nurse for assistance.

Thank you for your cooperation.

518-407-2552	518-434-0597	nurse@greentechhigh.org
Health Office Telephone	**Health Office FAX**	**Health Office Email**

GREEN TECH HIGH SCHOOL
CITY SCHOOL DISTRICT OF ALBANY BUREAU OF HEALTH AND PHYSICAL EDUCATION

Dental Health Certificate

Parent/Guardian: New York State Law requires school districts to request Dental Certificates for students when they enter school and in grades Pre-K, K, 1, 3, 5, 7, 9 and 11. Please complete Section 1 of this form and have your child's dental care provider complete Section 2. The dental assessment may be completed during or 12 months prior to the school year in which it is required. Return the completed form to the School Nurse by *January 1st*.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: (Last, First, Middle)

Birth Date: ___ /___ /___ Month /Day /Year	Sex: ☐ Male ☐ Female	Will this be your child's first visit to a dentist? ☐ Yes ☐ No
School:		Grade:

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? ☐ Yes ☐ No

Section 2. To be completed by the Dental Care Provider

Child's Name: ______________________________ Date of Exam: ________________

The dental exam may be completed during or 12 months prior to the school year in which it is required.

Check one:

[] Yes - The student listed above is in fit condition of dental health to permit his/her attendance at school.

[] No - The student listed above is not in fit condition of dental health to permit his/her attendance at school.
NOTE: Not in fit condition of dental health means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at school does not preclude the student from attending school.

Dental Care Provider's Name & Address: ______________________
____
____

Stamp:

Dental Care Provider's Signature: __________________________ Phone Number: ______________

<u>Oral Health Status</u> (check all that apply).

Caries Experience/Restoration History: ☐ **Yes** ☐ **No**
Has the child ever had a cavity (treated or untreated) or extraction?

Untreated Caries: ☐ **Yes** ☐ **No**
Does this child have an open cavity?

Dental Sealants Present ☐ **Yes** ☐ **No**

Fluoride Supplements: ☐ **Yes** ☐ **No**

Other Observations (Specify): ____
____

Treatment Needs (check all that apply)

☐ No obvious problem. Routine dental care is recommended.
☐ Immediate dental care is required.
☐ Requires an appointment with a dentist for further care.
☐ Date of Appointment: ____________________________________

H.E. 106 (Rev. 01/13)

CITY SCHOOL DISTRICT OF ALBANY

DEPARTMENT OF HEALTH AND PHYSICAL EDUCATION

SEASONAL SPORTS INTERVAL HEALTH HISTORY

Last Recorded Physical: ______

New Physical Required: ▯ YES ▯ NO

Sport: ______________ Level: N/A Grade: _____ Academy: N/A

SN Notations: ______________________

Student: ________________________________ **DOB:** ___________ **Age:** _____ **Sex: M / F**

Student ID No.: n/a Current School: GREEN TECH CHARTER HIGH SCHOOL **School Attended Last Year:** ________

Parent or Guardian: Prior to the tryout sessions or practice at the beginning of the each season, a health history review for each athlete must be conducted. The Health History must be returned to the Nurse's Office or the student will not be cleared to participate in the sport including tryouts. **This form needs to be completed each sport season:**

	Please answer the following questions:	YES	NO
1	Has the student had a medical illness or injury lasting more than five days since the last check up or sports physical?	▯	▯
2	Has the student ever been told not to participate in the sports for medical reasons?	▯	▯
3	Has the student ever experienced any type of head injury or concussion requiring medical attention? How many total concussions? (_____)	▯	▯
4	Has the student ever been denied or restricted from participation in sports due to any heart problems (heart disease, murmur, hypertension, or chest pain)?	▯	▯
5	Has the student experienced chest pain, dizziness, or fatigue after exercise?	▯	▯
6	Has any member of the student's immediate family, under the age of 50, died of heart problems or unexplained causes?	▯	▯
7	Has the student been diagnosed with asthma?	▯	▯
8	Has the student been prescribed with an inhaler? If yes, is a MD and parent note on file in the Health Office so that the student can self-carry inhaler?	▯	▯
9	Has the student ever had an allergic reaction to bees, food, medications etc.?	▯	▯
10	Has the student had other allergies?	▯	▯
11	Has the student ever had any problems with environmental heat (heat fatigue, heat exhaustion or heat stroke)?	▯	▯
12	Is the student missing an organ or is one significantly impaired (kidney, eye, ear, testicle)?	▯	▯
13	Does the student have any chronic illness (diabetes, seizures, bleeding disorder etc.)?	▯	▯
14	Has the student had any operations?	▯	▯
15	Has the student had a fracture, sprain or dislocation in the last year?	▯	▯
16	Is the student under a doctor's care now? (explain below)	▯	▯
17	Is the student taking medicine regularly? (explain below)	▯	▯
18	Does the student wear glasses, contact lenses, protective eye wear or orthodontic appliance during sports?	▯	▯

Explain "YES" Answers Here (identify each answer with question number) ______________________________

____

____

____

If your child may require medication during an athletic event, a medication permission form must be on file in the Health Office. Forms may be obtained from the School Nurse.

Parent/Guardian and Student: Please read the statements below, sign where indicated, and return this form to the School Nurse as soon possible.

- **To the best of my knowledge, all information provided in the health history is accurate.**
- **The above named student may participate in the interscholastic program of his/her school including practice sessions, events, and travel to and from athletic contests.**
- **I give permission for emergency medical treatment deemed necessary by physicians designated by school authorities.**

CONCUSSION STATEMENT

I certify that I have been provided with an information sheet on concussions in youth sports in compliance with NYSPHSAA and CDC's guidelines. If any player/participant is suspected of suffering a concussion or brain injury, the player will be removed from practice or competition and not returned to practice or competition until cleared in writing by a licensed health care provider trained in evaluation and management of concussions, and the school chief medical officer.

ATHLETIC INJURY WARNING STATEMENT

Participation in the Interscholastic Athletic Program is on a voluntary basis. Parents/guardians and students should realize that, as in any athletic activity, there is an element of risk involved whereas physical injuries may occur. Please be assured that our school officials will utilize all precautionary measures to safeguard the student's/athlete's health. Please note, however, that in the event of athletic injury to your child, the parents/guardians are responsible for medical and/or hospital expenses incurred. The School District does carry a Supplementary Insurance Plan to assist parents when their own personal health insurance does not cover the entire medical and/or hospital expense. Medical insurance information can be obtained by calling the District Office.

YOUR CHILD MAY NOT PARTICIPATE IN INTERSCHOLASTIC SPORTS OR PRACTICES UNTIL THE REQUIRED PHYSICAL AND HISTORY HAS BEEN REVIEWED BY THE SCHOOL NURSE.

PARENT/GUARDIAN SIGNATURE: ______________________________ **DATE:** ______________

STUDENT SIGNATURE: ____________________________________ **DATE:** ______________

Home Phone: ______________ **Work Phone:** ______________ **Cell Phone:** ________________