



# BPS Athletics Team Registration – 20\_\_\_\_\_

SEND REGISTRATION TO: BPS Athletics, fax: 851-3561 or email: [alloyd@buffaloschools.org](mailto:alloyd@buffaloschools.org)

Registration for sports participation is required.

## STUDENT - ATHLETE INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age as of July 1: \_\_\_\_\_ Grade: \_\_\_\_\_

Assigned School: \_\_\_\_\_

Sport: \_\_\_\_\_ Level (circle one): Modified Junior Varsity Varsity

T-shirt Size (circle one): Youth - S M L XL | Adult- S M L XL XXL

## PARENT/GUARDIAN INFORMATION

Parent/Guardian's Name: \_\_\_\_\_

Phone #'s: Daytime: \_\_\_\_\_ Evening: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

- I, the undersigned, hereby grant permission for my child to participate under an assigned coach in the BPS Athletics program. (Parent)
- We (parent and student) understand that a physical is required to participate on this team.
- We (parent and student) understand and accept the risks inherent to participation in competitive sports. Because of the dangers of participating in sports, we recognize the importance of listening to and following all of the coach's instructions and warnings regarding playing techniques, training, equipment and other team rules, etc. both in competition and in practice and agree to obey such instructions. We also recognize the importance of reading and adhering to written instructions and written warnings regarding playing techniques, training methods, rules of the sport and other team rules, etc, both in competition and in practice and agree to obey such instructions.
- We (parent and student) have read the Parent & Athlete Concussion Information Sheet.
- We (parent and student) have read and agree to the above conditions. (Both)

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Student-athlete: \_\_\_\_\_ Date: \_\_\_\_\_



**INTERVAL HEALTH HISTORY FOR SPORTS PARTICIPATION**  
**Buffalo Public Schools**

**SCHOOL NAME:** \_\_\_\_\_

Prior to the start of tryout sessions or practice at the beginning of each sports season, an interval health history for each athlete must be conducted unless the student received a full medical examination within 30 days of the start of the season.

**PART A: TO BE COMPLETED BY THE PARENT OR GUARDIAN**

Student: \_\_\_\_\_ Sex: M / F  
Grade (check): 7    8    9    10    11    12    Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Sport: \_\_\_\_\_ Level (check): Varsity    JV    Modified    Jr. High

SCHOOL NURSE COMPLETES... Date of last health appraisal: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Limitations: Yes    No

**PART B: TO BE COMPLETED BY THE PARENT OR GUARDIAN**

Please complete and return to the school health office by: \_\_\_\_\_

**Note:** A "Yes" to any of these questions does not mean automatic disqualification from the athletic activity indicated in PART A above. However, it will require a review and approval by the school physician before the student can report to practice or tryouts. The answers to the questions on this form will be held in the school health office, and will be kept confidential.

**HISTORY SINCE LAST HEALTH APPRAISAL:**

If the answer to any of the following questions is "YES", in PART C on the reverse side of this form, describe the condition or situation that prompted your answer.

- |    |  |     |    |
|----|--|-----|----|
| 1. | Any injuries requiring medical attention?  | Yes | No |
| 2. | Any illness lasting more than five (5) days?                                     | Yes | No |
| 3. | Taking medicine or under physician's care at this time?                          | Yes | No |
| 4. | Any feeling of faintness, dizziness or fatigue with/ after exercise or exertion? | Yes | No |
| 5. | Change in wearing glasses or contact lenses?                                     | Yes | No |
| 6. | Any surgical operations or fractures?  | Yes | No |
| 7. | Any treatment in a hospital or emergency room?                                   | Yes | No |
| 8. | Developed any allergies?   | Yes | No |
| 9. | Any chronic disease?   | Yes | No |

**PART C: TO BE COMPLETED BY PARENT OR GUARDIAN**

Describe the condition or situation that caused any questions in PART B to be answered "YES".

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**PART D: PARENTAL PERMISSION**

I, the undersigned, clearly understand these questions are asked in order to decide if my child can safely participate on the athletic team named in PART A of this form. The answers are correct as of this date and he/she has my permission to participate.

SIGNED: \_\_\_\_\_ DATE: \_\_\_/\_\_\_/\_\_\_

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**PART E: TO BE COMPLETED BY THE SCHOOL NURSE**

Sports Participation:     Approved                     Referred to School Physician

Signed: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_  
  School Nurse

If referred to the School Physician:

Re-qualified                     Disqualified

Signed: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_  
  School Physician



# HEALTH CERTIFICATE / APPRAISAL FORM

CSE Referral Date \_\_\_\_\_

Initial    Re-evaluation    Emergency Evaluation

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
School: \_\_\_\_\_ Gender:  M  F Grade: \_\_\_\_\_

### IMMUNIZATIONS / HEALTH HISTORY

- Immunization record attached
  - No immunizations given today
  - Immunizations given since last Health Appraisal:
- Sickle Cell Screen  Positive  Negative Date: \_\_\_\_\_  
 PPD:  Positive  Negative Date: \_\_\_\_\_  
 Lead Screening:  Yes  No Date: \_\_\_\_\_  
 Dental Referral:  Yes  No Date: \_\_\_\_\_

Significant Medical/Surgical History:  See attached \_\_\_\_\_

Specify current diseases:  Asthma    Diabetes:  Type 1     Type 2     Hyperlipidemia     Hypertension  
 Other: \_\_\_\_\_

Asthma Severity: Intermittent    Mild Persistent    Moderate Persistent    Severe Persistent    Inhaler \_\_\_\_\_

Allergies:  LIFE THREATENING     Food: \_\_\_\_\_     Insect: \_\_\_\_\_     Other: \_\_\_\_\_  
 Seasonal     Medication: \_\_\_\_\_

### PHYSICAL EXAM

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Pulse: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

Body Mass Index: _____ Weight Status Category (BMI Percentile): <input type="checkbox"/> less than 5 <sup>th</sup> <input type="checkbox"/> 5 <sup>th</sup> through 49 <sup>th</sup> <input type="checkbox"/> 50 <sup>th</sup> through 84 <sup>th</sup> <input type="checkbox"/> 85 <sup>th</sup> through 94 <sup>th</sup> <input type="checkbox"/> 95 <sup>th</sup> through 98 <sup>th</sup> <input type="checkbox"/> 99 <sup>th</sup> and higher	Vision - without glasses/contact lenses	R	L	<i>Referral</i>
	Vision - with glasses/contact lenses	R	L	
	Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R	L	

EXAM ENTIRELY NORMAL    Tanner: I.    II.    III.    IV.    V.    Scoliosis:  Negative  Positive: \_\_\_\_\_

Specify any abnormality (use reverse of form if needed): \_\_\_\_\_

### MEDICATIONS

Medications :  None     Yes, see attached list

### PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

- Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:
  - \_\_\_ Contact/Collision: basketball, diving, field hockey, football, ice hockey, lacrosse, martial arts, soccer, wrestling, team handball, water polo
  - \_\_\_ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
  - \_\_\_ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.
- Specify medical accommodations needed for school: \_\_\_\_\_  None
- Known or suspected disability: \_\_\_\_\_  Please monitor
- Restrictions: \_\_\_\_\_  Please monitor
- Protective equipment required:  Athletic Cup     Sport goggles/impact resistant eyewear     Other: \_\_\_\_\_

Provider's Signature: \_\_\_\_\_ Phone: \_\_\_\_\_ (Stamp below)

Provider's Name/Address: \_\_\_\_\_ Fax: \_\_\_\_\_

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

NYS Education Department requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 & 10, sports, working permits, and, triennially, for the Committee on Special Education (CSE). This exam is valid for one year through the last day of the month dated below with the exception of any illness or injury lasting more than five days that will negate this exam.

## CONCUSSION INFORMATION SHEET



This sheet has information to help protect your children or teens from concussion or other serious brain injury. Use this information at your children's or teens' games and practices to learn how to spot a concussion and what to do if a concussion occurs.

### WHAT IS A CONCUSSION?

A concussion is a type of traumatic brain injury—or TBI—caused by a bump, blow, or jolt to the head or by a hit to the body that causes the head and brain to move quickly back and forth. This fast movement can cause the brain to bounce around or twist in the skull, creating chemical changes in the brain and sometimes stretching and damaging the brain cells.

### HOW CAN I SPOT A POSSIBLE CONCUSSION?

Children and teens who show or report one or more of the signs and symptoms listed below—or simply say they just “don’t feel right” after a bump, blow, or jolt to the head or body—may have a concussion or other serious brain injury.

#### SIGNS OBSERVED BY PARENTS OR COACHES

- Appears dazed or stunned.
- Forgets an instruction, is confused about an assignment or position, or is unsure of the game, score, or opponent.
- Moves clumsily.
- Answers questions slowly.
- Loses consciousness (even briefly).
- Shows mood, behavior, or personality changes.
- Can't recall events prior to or after a hit or fall.

#### SYMPTOMS REPORTED BY CHILDREN AND TEENS

- Headache or “pressure” in head.
- Nausea or vomiting.
- Balance problems or dizziness, or double or blurry vision.
- Bothered by light or noise.
- Feeling sluggish, hazy, foggy, or groggy.
- Confusion, or concentration or memory problems.
- Just not “feeling right,” or “feeling down.”

## WHAT ARE SOME MORE SERIOUS DANGER SIGNS TO LOOK OUT FOR?

In rare cases, a dangerous collection of blood (hematoma) may form on the brain after a bump, blow, or jolt to the head or body and can squeeze the brain against the skull. Call 9-1-1 or take your child or teen to the emergency department right away if, after a bump, blow, or jolt to the head or body, he or she has one or more of these danger signs:

- One pupil larger than the other.
- Drowsiness or inability to wake up.
- A headache that gets worse and does not go away.
- Slurred speech, weakness, numbness, or decreased coordination.
- Repeated vomiting or nausea, convulsions or seizures (shaking or twitching).
- Unusual behavior, increased confusion, restlessness, or agitation.
- Loss of consciousness (passed out/knocked out). Even a brief loss of consciousness should be taken seriously.

## WHAT SHOULD I DO IF MY CHILD OR TEEN HAS A POSSIBLE CONCUSSION?

As a parent, if you think your child or teen may have a concussion, you should:

1. Remove your child or teen from play.
2. Keep your child or teen out of play the day of the injury. Your child or teen should be seen by a health care provider and only return to play with permission from a health care provider who is experienced in evaluating for concussion.
3. Ask your child's or teen's health care provider for written instructions on helping your child or teen return to school. You can give the instructions to your child's or teen's school nurse and teacher(s) and return-to-play instructions to the coach and/or athletic trainer.

Do not try to judge the severity of the injury yourself. Only a health care provider should assess a child or teen for a possible concussion. Concussion signs and symptoms often show up soon after the injury. But you may not know how serious the concussion is at first, and some symptoms may not show up for hours or days.

The brain needs time to heal after a concussion. A child's or teen's return to school and sports should be a gradual process that is carefully managed and monitored by a health care provider.

## HOW CAN I HELP KEEP MY CHILDREN OR TEENS SAFE?

Sports are a great way for children and teens to stay healthy and can help them do well in school. To help lower your children's or teens' chances of getting a concussion or other serious brain injury, you should:

- Help create a culture of safety for the team.
  - » Work with their coach to teach ways to lower the chances of getting a concussion.
  - » Talk with your children or teens about concussion and ask if they have concerns about reporting a concussion. Talk with them about their concerns; emphasize the importance of reporting concussions and taking time to recover from one.
  - » Ensure that they follow their coach's rules for safety and the rules of the sport.
  - » Tell your children or teens that you expect them to practice good sportsmanship at all times.
- When appropriate for the sport or activity, teach your children or teens that they must wear a helmet to lower the chances of the most serious types of brain or head injury. However, there is no "concussion-proof" helmet. So, even with a helmet, it is important for children and teens to avoid hits to the head.



TO LEARN MORE GO TO >> [cdc.gov/HEADSUP](http://cdc.gov/HEADSUP)

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