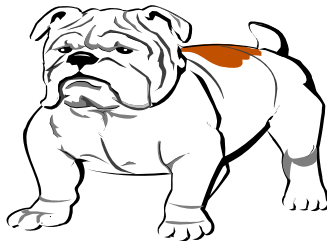


ISLAND TREES HIGH SCHOOL

ATHLETIC DEPARTMENT



Attention All Parents and Guardians Of 9th through 12th Graders

This information is important to you if your child intends to tryout or participate on one of the Varsity or Junior Varsity School Athletic Teams.

All 9th and 12th graders must have a **Medical/Athletic Physical** and an **Athletic Permission Form** on file in the nurse's office. Medical/Athletic Physicals are valid for one year from the date the physical was administered. This means if your child attended the school physical offered in June of 2009 he/she is cleared for sports for the 2009-10 school year. If not, you will need to obtain a physical before the sports season begins. Medical/Athletic Physicals and Athletic Permission Forms can be obtained from the district website (www.islandtrees.org) on the athletic page or in the Athletic Office in the Middle School.

High School Sports Season Varsity and JV

Fall

August 31, 2009

Cross Country	Boys
Cross Country	Girls
Soccer	Boys
Soccer	Girls
Volleyball	Girls
Golf	Boys
Cheerleading	Girls
Kick line	Girls
*Football	Boys

*Football begins **August 19, 2009**

Winter

Nov. 18, 2009

Basketball	Boys
Basketball	Girls
Bowling	Boys
Bowling	Girls
Winter Track	Boys
Winter Track	Girls
*Wrestling	Boys

*Wrestling begins **Nov. 16, 2009**

Spring

March 8, 2010

Baseball	Boys
Softball	Girls
Lacrosse	Boys
Lacrosse	Girls
Spring Track	Girls
Spring Track	Boys
*Badminton	Girls

Badminton Begins **March 15, 2010**

ISLAND TREES PUBLIC SCHOOLS

Medical/Athletic Physical

LAST NAME _____ FIRST _____ MALE/FEMALE GRADE _____

DATE OF BIRTH _____ LAST TETANUS VACCINE _____

MEDICAL/SURGICAL HISTORY _____

SPECIFY CURRENT CONDITIONS: ASTHMA ___ DIABETES 1 ___ DIABETES 2 ___

PREHYPERTENSION ___ HYPERTENSION ___

OTHER ___

ALLERGIES. _____ HEART RATE _____

HEIGHT _____ WEIGHT _____ BLOOD PRESSURE _____ DATE OF EXAM. _____

REQUIRED BY NYS DEPT. OF HEALTH

BODY MASS INDEX: _____	WEIGHT STATUS CATEGORY (BMI PERCENTILE):
	Less than 5 th ___ 5 th thru 49 th ___ 50 th thru 84 th ___
	85 th thru 94 th ___ 95 th thru 98 th ___ 99 th and higher ___
PRIMARY RACE/ETHNICITY: White ___ Black ___ Hispanic ___ Asian ___ Other ___	

Heart _____ Eyes _____ Ears _____ Lymph Nodes _____ Thyroid _____
 Throat _____ Teeth _____ Lungs _____ Abdomen _____ Hernia _____
 Genito-Urinary _____ Orthopedic _____ Skin _____ Nervous System _____
 Speech _____ Scoliosis: Neg ___ Pos ___

This certifies that the above patient is physically qualified to participate in the following categories of competition during the school year. Please mark with an "X" all categories allowed.

- CONTACT/COLLISION SPORTS (Football, Baseball, Basketball, Soccer, Wrestling, Lacrosse, Softball)
- ENDURANCE ACTIVITIES (Track, Cross Country, Volleyball)
- OTHERS (Bowling, Golf, Cheerleading, Kickline, Field Events)

Reason for disqualification _____

Referrals : _____

Add any information you feel might be helpful in understanding or planning for this child :

DATE _____ PHYSICIAN'S SIGNATURE : _____

STAMP :

This exam complies with NYSED requirements and is valid for 12 months, with the exception of any illness or injury lasting more than five days that will require review by private physician or specialist.

ISLAND TREES ATHLETIC PERMISSION FORM

PART I

Parent/Legal Guardian complete Part I and II

CHILD'S NAME _____ DATE OF BIRTH _____

ADDRESS _____

PHONE _____ SEX _____ GRADE _____

FAMILY PHYSICIAN _____ PHONE _____

INTERSCHOLASTIC MEDICAL/SURGICAL HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Please check each item Yes or No	NO	EXPLANATION	
		YES	DATE(S)
1. Eye Disorder			
Loss of Vision in One Eye			
Detached Retina			
Cataract			
Contact Lens ✓			
2. Ear Disorder			
Hearing Loss			
Tubes			
3. Nose Disorder			
Fractures			
Frequent Nose Bleeds			
4. Throat Disorder			
Tonsillectomy			
Thyroid Condition			
5. Dental Disorder, Braces, Caps, Bonding ✓			
6. Heart Murmur, Rheumatic Fever			
7. Lungs Pneumonia, Bronchitis, Asthma			
8. Kidney, Bladder Disorder, Loss of Kidney			
9. Abdominal, Intestinal Disorders			
10. Hernia, Varicocele, Hydrocele			
11. Undescended Testicle, Loss of Testicle			
12. Bones/Joints, Fractures, Dislocation			
Chondromalacia, Osgood Schlatter			
Artificial Limb Splint/Brace			
13. Muscle Sprains			
14. Head Injury, Seizure Disorder			
Loss of Consciousness			
15. Allergies			
16. Prescribed Med.-Regular Basis/Dosage			
17. Operations			
18. Diabetes			
19. Hospital Admissions			

PARENT/GUARDIAN SIGNATURE

DATE

PART II

PARENT: PLEASE SIGN YOUR FULL NAME next to EACH sport you will allow YOUR child to play in the coming year.

*BADMINTON _____

LACROSSE _____

BASEBALL _____

SOCCER _____

BASKETBALL _____

SOFTBALL _____

*BOWLING _____

*SWIMMING _____

*CHEERING _____

TRACK _____

*CROSS COUNTRY _____

VOLLEYBALL _____

FOOTBALL _____

*WINTER TRACK _____

*GOLF _____

WRESTLING _____

*GYMNASTICS _____

DATE OF LAST TETANUS SHOT _____

*KICKLINE _____

*INDICATES A H.S. LEVEL TEAM

STUDENT INSURANCE COVERAGE

The district's insurance coverage of student activities, at one time restricted to participants in interscholastic sports, is now extended to include all students participating in school sponsored activities - both curricular and co-curricular.

This is minimal coverage, however, because the Pupil Benefits Plan, sponsored by the New York State Public High School Athletic Association, the only accident insurance we are able to obtain, provides limited benefits. We strongly recommend, therefore, that parents examine their own medical insurance policies to be sure that adequate coverage is available, if needed.

✓ PERMISSION LETTER FOR CONTACT LENSES AND ORTHODONTIC APPLIANCES

My child, _____, has my permission to engage in all physical education programs and/or athletic activities while wearing his/her contact lenses and/or orthodontic appliances. I understand that there is a possibility of loss of or damage to the lenses or appliances during participation by my child in such activities. I recognize that the lenses and/or appliances can be lost, crushed or damaged during body contact activities and other vigorous exercise. I am willing to take calculated risks involved and assume responsibility for replacement of the above should they be lost or broken.

CONTACT LENSES

ORTHODONTIC APPLIANCES

SIGNATURE OF PARENT OR GUARDIAN