STATEN ISLAND ACADEMY INTERSCHOLASTIC ATHLETICS

PARENT/STUDENT CONSENT FORM – UPPER SCHOOL

Student's Name: ____ **Grade: ____________**

Address: ____ **Date of Birth: ________**

Parent/ Guardian #1: _______________________________________

Parent / Guardian #2: _______________________________________

PARENT / GUARDIAN CONSENT:

I hereby give permission for my child to participate on the following team: **CIRCLE ONE ONLY**

FALL: CROSS COUNTRY SOCCER GIRLS' TENNIS GIRLS' VOLLEYBALL

WINTER: BASKETBALL SWIMMING

SPRING: BADMINTON BASEBALL GOLF GIRLS' LACROSSE

SOFTBALL BOYS' TENNIS BOYS' VOLLEYBALL

I understand that Staten Island Academy will not assume responsibility should an accident occur to my child during participation in any phase of the athletic program. I also understand that participation in this sport may involve strenuous physical activity and bodily contact and, consequently, may result in injuries causing complete or partial paralysis, permanent physical or mental incapacitation, or loss of life. I also understand that my child will be obligated to attend all practices and that failure to do so may constitute grounds for exclusion from the team. I acknowledge that I have read and understand this warning. I give my child permission to travel to and from all contests, scrimmages, and practices in or out of New York City, and agree to be responsible for the return of all equipment issued by the school to him/her. I also understand that it is necessary for my child to have had and passed a physical exam given by a physician and to have a record on file in the school before trying out, practicing, or competing in interscholastic activities. I also agree to inform the school of any change in my child's medical or physical condition, which develops or is discovered at any time after the date this document is signed.

STUDENT CONSENT:

I hereby request permission to enroll as a candidate for a place on each of the teams noted above. I understand that in order to participate, I must:

1) Have on file in the Athletic Office this consent form signed by a parent/guardian, giving approval.
2) Pass a physical examination given by a physician and have a record of that exam on file at the Academy.
3) Agree to obey all regulations, including those pertaining to practice periods and team rules as established by the coaches, and to conduct myself with class and dignity, both on and off the fields and/or courts at all times. Failure to do so may result in suspension or dismissal from the team.
4) Be responsible for the care and safe return of all school equipment issued to me, and I will personally bring it to the coach or appropriate member of the Athletic Department.
5) **Have completely read and understand this Consent Form and the Athletic Handbook on the Academy website**.

______________________________________ ______________

Signature of Student Date

______________________________________ ______________

Signature of Parent / Guardian Date

STATEN ISLAND ACADEMY INTERSCHOLASTIC ATHLETICS

PARENT/STUDENT CONSENT FORM – MIDDLE SCHOOL

Student's Name: ____ Grade: ____________

Address: ____ Date of Birth: ________

Parent/ Guardian #1: _______________________________________

Parent / Guardian #2: _______________________________________

PARENT / GUARDIAN CONSENT:

I hereby give permission for my child to participate on the following team: - **CIRCLE ONE ONLY**

FALL: SOCCER (CO-ED) GIRLS' VOLLEYBALL

WINTER: BASKETBALL SWIMMING

SPRING: BASEBALL SOCCER SOFTBALL

I understand that Staten Island Academy will not assume responsibility should an accident occur to my child during participation in any phase of the athletic program. I also understand that participation in this sport may involve strenuous physical activity and bodily contact and, consequently, may result in injuries causing complete or partial paralysis, permanent physical or mental incapacitation, or loss of life. I also understand that my child will be obligated to attend all practices and that failure to do so may constitute grounds for exclusion from the team. I acknowledge that I have read and understand this warning. I give my child permission to travel to and from all contests, scrimmages, and practices in or out of New York City, and agree to be responsible for the return of all equipment issued by the school to him/her. I also understand that it is necessary for my child to have had and passed a physical exam given by a physician and to have a record on file in the school before trying out, practicing, or competing in interscholastic activities. I also agree to inform the school of any change in my child's medical or physical condition, which develops or is discovered at any time after the date this document is signed.

STUDENT CONSENT:

I hereby request permission to enroll as a candidate for a place on each of the teams noted above. I understand that in order to participate, I must:

1) Have on file in the Athletic Office this consent form signed by a parent/guardian, giving approval.
2) Pass a physical examination given by a physician and have a record of that exam on file at the Academy.
3) Agree to obey all regulations, including those pertaining to practice periods and team rules as established by the coaches, and to conduct myself with class and dignity, both on and off the fields and/or courts at all times. Failure to do so may result in suspension or dismissal from the team.
4) Be responsible for the care and safe return of all school equipment issued to me, and I will personally bring it to the coach or appropriate member of the Athletic Department.
5) **Have completely read and understand this Consent Form and the Athletic Handbook on the Academy website**.

______________________________________ ______________

Signature of Student Date

______________________________________ ______________

Signature of Parent / Guardian Date

STATEN ISLAND ACADEMY
EMERGENCY CONTACT FORM

To Be Completed by the Parent or Guardian:

Student Name: ____ Sex: ☐ Male ☐ Female
Last First Middle

Address: ________________________________ Birth Date ☐ ☐-☐ ☐-☐ ☐

City/State/Zip ________________________________ Grade ______________

Home Phone # ________________ Mother's Work # ____________________

Father's Work #________________ Additional Phone# ____________________

Please list contact person(s) who can be reached, if above are unavailable, who can give permission for emergency treatment:

Name:________________________ Phone____________ Relationship__________

Name:________________________ Phone____________ Relationship__________

Does your child wear contact lenses? ☐ Yes ☐ No

Date of last tetanus shot: ☐ ☐-☐ ☐-☐ ☐

List any medications your child may be taking:

____

List any allergic reactions that we should be aware of:

____

Additional information which would be helpful in an emergency:

____

Please read and sign the following statement:

I, ______________________________________, do hereby give permission for an attending emergency physician to give medical treatment to my child, ________________________, in case of an emergency in my absence. I am executing a written copy and a carbon copy of this permission, and the physician relying on this permission my do so even though what is being exhibited is a carbon or photocopy of the same and a carbon or photocopy of my signature.

Parent/Guardian Signature: ________________________ Date: ____________

Staten Island Academy
715 Todt Hill Road
Staten Island, NY 10304

Recommended NYSED Interval Health History for Athletics

Student Name:	DOB
School Name:	Age
Grade (check): ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12	Limitations: ☐ NO ☐ YES
Sport	Date of last Health Exam:
Sport Level: ☐ Modified ☐ Fresh ☐ JV ☐ Varsity	Date form completed:

MUST be completed and signed by Parent/Guardian - Give details to any YES answers on the last page.

Does or Has Your Child

General Health	No	Yes
Ever been restricted by a health care provider from sports participation for any reason?	☐	☐
Ever had surgery?	☐	☐
Ever spent the night in a hospital?	☐	☐
Been diagnosed with mononucleosis within the last month?	☐	☐
Have only one functioning kidney?	☐	☐
Have a bleeding disorder?	☐	☐
Have any problems with hearing or have congenital deafness?	☐	☐
Have any problems with vision or only have vision in one eye?	☐	☐
Have an ongoing medical condition?	☐	☐

If yes, check all that apply:

☐ Asthma ☐ Diabetes
☐ Seizures ☐ Sickle cell trait or disease
☐ Other:

	No	Yes
Have Allergies?	☐	☐

If yes, check all that apply

☐ Food ☐ Insect Bite ☐ Latex ☐ Medicine
☐ Pollen ☐ Other:

	No	Yes
Ever had anaphylaxis?	☐	☐
Carry an epinephrine auto-injector?	☐	☐

Brain/Head Injury History	No	Yes
Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told they had a concussion?	☐	☐
Receive treatment for a seizure disorder or epilepsy?	☐	☐
Ever had headaches with exercise?	☐	☐
Ever had migraines?	☐	☐

Does or Has Your Child

Breathing	No	Yes
Ever complained of getting extremely tired or short of breath during exercise?	☐	☐
Use or carry an inhaler or nebulizer?	☐	☐
Wheeze or cough frequently during or after exercise?	☐	☐
Ever been told by a health care provider they have asthma or exercise-induced asthma?	☐	☐

Devices / Accommodations	No	Yes
Use a brace, orthotic, or another device?	☐	☐
Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)?	☐	☐
Wear protective eyewear, such as goggles or a face shield?	☐	☐
Wear a hearing aid or cochlear implant?	☐	☐

Let the coach/school nurse know of any device used. Not required for contact lenses or eyeglasses.

Digestive (GI) Health	No	Yes
Have stomach or other GI problems?	☐	☐
Ever had an eating disorder?	☐	☐
Have a special diet or need to avoid certain foods?	☐	☐
Are there any concerns about your child's weight?	☐	☐

Injury History	No	Yes
Ever been unable to move their arms or legs or had tingling, numbness, or weakness after being hit or falling?	☐	☐
Ever had an injury, pain, or swelling of a joint that caused them to miss practice or a game?	☐	☐
Have a bone, muscle, or joint that bothers them?	☐	☐
Have joints that become painful, swollen, warm, or red with use?	☐	☐
Ever been diagnosed with a stress fracture?	☐	☐

Student Name:		DOB:	

Does or Has Your Child		
Heart Health		
Ever complained of:		
Ever had a test by a health care provider for their heart (e.g., EKG, echocardiogram, stress test)?	☐	☐
Lightheadedness, dizziness, during or after exercise?	☐	☐
Chest pain, tightness, or pressure during or after exercise?		
Fluttering in the chest, skipped heartbeats, heart racing?	☐	☐
Ever been told by a health care provider they have or had a heart or blood vessel problem?	☐	☐

If yes, check all that apply:

- ☐ Chest Tightness or Pain
- ☐ Heart infection
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ High Cholesterol
- ☐ Low Blood Pressure
- ☐ New fast or slow heart rate
- ☐ Kawasaki Disease
- ☐ Has implanted cardiac defibrillator (ICD)
- ☐ Has a pacemaker
- ☐ Other:

Does or Has Your Child		
Females Only	**No**	**Yes**
Have regular periods?	☐	☐
Males Only	**No**	**Yes**
Have only one testicle?	☐	☐
Have groin pain or a bulge, or a hernia?	☐	☐
Skin Health	**No**	**Yes**
Currently have any rashes, pressure sores, or other skin problems?	☐	☐
Ever had a herpes or MRSA skin infection?	☐	☐
COVID-19 Information		
Has your child ever tested positive for COVID-19?	☐	☐
If **NO, STOP.** Go to Family Heart Health History. If **YES,** answer questions below:		
Date of positive COVID test:		
Was your child symptomatic?	☐	☐
Did your child see a health care provider for their COVID-19 symptoms?	☐	☐
Was your child hospitalized for COVID?	☐	☐
Was your child diagnosed with Multisystem Inflammatory Syndrome (MISC)?	☐	☐

Family Heart Health History

A relative has/had any of the following:

Check all that apply:

- ☐ Enlarged Heart/ Hypertrophic Cardiomyopathy/ Dilated Cardiomyopathy
- ☐ Arrhythmogenic Right Ventricular Cardiomyopathy?
- ☐ Heart rhythm problems, long or short QT interval?
- ☐ Brugada Syndrome?
- ☐ Catecholaminergic Ventricular Tachycardia?
- ☐ Marfan Syndrome (aortic rupture)?
- ☐ Heart attack at age 50 or younger?
- ☐ Pacemaker or implanted cardiac defibrillator (ICD)?

A family history of:

- ☐ Known heart abnormalities or sudden death before age 50?
- ☐ Structural heart abnormality, repaired or unrepaired?
- ☐ Unexplained fainting, seizures, drowning, near drowning, or car accident before age 50?

If you answered **NO** to ***all*** questions, **STOP**. Sign and date below.
GO to page 3 if you answered **YES** to a question.

Parent/Guardian Signature:		Date:	

Student Name:		DOB:	

If you answered **YES** to any questions give details. Sign and date below.

Parent/Guardian Signature:		Date: