ATHLETIC CODE OF CONDUCT

ACKNOWLEDGEMENT OF RECEIPT OF ATHLETIC HANDBOOK

PLEASE DETACH THIS PAGE AND RETURN TO YOUR COACH

Parent/guardians must understand and agree to the conditions for involvement for their son or daughter in order for them to participate in athletics. Parent(s) or guardian(s) shall read all of the enclosed material and acknowledge understanding of the athletic eligibility rules and policies. The parent(s) or guardian(s) shall sign and return the Responsibility Acknowledgement Agreement to the Athletic Department prior to participating in any practice or contests.

I have read the Stockbridge Valley Central School District Code of Interscholastic Athletics including the rules, regulations and policies. I fully understand its meaning and consequences and support its enforcement by persons responsible.

Please sign and return to your coach. This needs to be done only once per year at Stockbridge Valley High School. This form will be kept on file in the Athletic Administrator's office. Thank you for your cooperation and support. You may not participate in interscholastic athletics until this form is signed and returned to your coach.

Signature of athlete

_____ _____
Date

Signature of parent(s) or legal guardian(s)

_____ _____
Date

_____ _____
Date

Received by the Athletic Department _____
(Date)

Stockbridge Valley Central School District
Legal Ref.: NYS Education Law §1709; Matter of Clark, 21 E. Dept. Rep. 542.
Adopted: 05/17/88 Readopted: 12/13/11
Revised: 07/10/90, 07/11/01, 08/03/04, 08/14/07, 07/07/09
Approved by the Superintendent: 06/13/17, 07/11/17, 01/19/18, 12/21/18, 10/08/19, 8/13/24

STOCKBRIDGE VALLEY CENTRAL SCHOOL DISTRICT
ATHLETIC PERMISSION AND MEDICAL CONSENT FORM

WARNING: BY ITS NATURE, PARTICIPATING IN INTERSCHOLASTIC ATHLETICS INCLUDES A RISK OF INJURY WHICH MAY RANGE IN SEVERITY FROM MINOR TO DISABLING TO EVEN DEATH. Although serious injuries are not common in supervised school athletic programs, it is impossible to eliminate the risk. Participants can, and have the responsibility to help reduce the chance of injury. PLAYERS MUST OBEY ALL SAFETY RULES, REPORT ALL PHYSICAL PROBLEMS TO THEIR COACHES, FOLLOW A PROPER CONDITIONING PROGRAM, AND INSPECT THEIR EQUIPMENT WEEKLY.

We have read and understand the Athletic Training and Behavior Code of Stockbridge Valley Central School and agree to comply. I have authority to sign this athletic permission and medical consent form on behalf of the Student Athlete named below. Subject to the approval of the school physician, I give my permission for _____ to participate in the following sports at Stockbridge Valley Central School during the 2_____ - 2_____ school year.

Fall _____ Date:_____ _____
Signature of Parent or Legal Guardian

Winter _____

Spring _____ Date:_____ _____
Signature of Student Athlete

To All Parents,

For your child's welfare, will you please fill in the following form and return it to Coach _____ as soon as possible. This information will only be used in the event that an emergency occurs involving your child.
Athletic Director

EMERGENCY INFORMATION CARD/CONSENT FOR EMERGENCY TREATMENT

Student's Name: _____ Grade: _____

Parent's or Legal Guardian's Name: _____

Street Address: _____

Home Phone: _____ Work Phone: _____

Your Health Insurance Plan: _____

Emergency Number if Not at Home or Work Number: _____

A Second Emergency Contact Person: _____

A Second Emergency Contact Person's Phone Number: _____

Student's Allergies: _____

I have authority to sign this consent for emergency treatment form on behalf of the student athlete named above. I hereby authorize the District or its designee to engage medical personnel to initiate any medical treatment or care. I agree to be responsible for the costs of all medical care expenses incurred to treat the Student Athlete. I hereby waive on behalf of myself and the above-named child any liability of the District, and of its agents or employees, arising out of such medical treatment.

Date: _____ _____
Signature of Parent or Legal Guardian

CONCUSSIONS AFFECT EACH CHILD AND TEEN DIFFERENTLY.

While most children and teens with a concussion feel better within a couple of weeks, some will have symptoms for months or longer. Talk with your children's or teens' healthcare provider if their concussion symptoms do not go away, or if they get worse after they return to their regular activities.

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

Children and teens who continue to play while having concussion symptoms, or who return to play too soon—while the brain is still healing—have a greater chance of getting another concussion. A repeat concussion that occurs while the brain is still healing from the first injury can be very serious, and can affect a child or teen for a lifetime. It can even be fatal.

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 healthcare provider and only return to play with permission from a healthcare provider who is experienced in evaluating for concussion.
3. Ask your child's or teen's healthcare 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 healthcare 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 healthcare provider.

To learn more, go to cdc.gov/HEADSUP

CDC HEADS UP

Discuss the risks of concussion and other serious brain injuries with your child or teen, and have each person sign below.

Detach the section below, and keep this information sheet to use at your children's or teens' games and practices to help protect them from concussion or other serious brain injuries.

○ I learned about concussion and talked with my parent or coach about what to do if I have a concussion or other serious brain injury.

Athlete's Name Printed:_____ Date:_____

Athlete's Signature:_____

○ I have read this fact sheet for parents on concussion with my child or teen, and talked about what to do if they have a concussion or other serious brain injury.

Parent or Legal Guardian's Name Printed:_____ Date:_____

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.

SINCE YOUR CHILD'S LAST HEALTH EXAM – HAS YOUR CHILD?

GENERAL HEALTH	NO	YES
Been restricted by a health care provider from sports participation for any reason?	☐	☐
Had surgery?	☐	☐
Spent the night in a hospital?	☐	☐
Been diagnosed with mononucleosis within the last month?	☐	☐
Has only one functioning kidney?	☐	☐
Has or had a bleeding disorder?	☐	☐
Having problems with hearing or have congenital deafness?	☐	☐
Having problems with vision or only have vision in one eye?	☐	☐
Been diagnosed with a new medical condition?	☐	☐
If yes, check all that apply: ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Sickle cell trait or disease ☐ Other:		
Developed Allergies?	☐	☐
If yes, check all that apply ☐ Food ☐ Insect Bite ☐ Latex ☐ Medicine ☐ Other: ☐ Pollen		
Had anaphylaxis?	☐	☐
Carry an epinephrine auto-injector?	☐	☐
Had or has groin pain, a bulge, or a hernia?	☐	☐
DEVICES / ACCOMMODATIONS	**NO**	**YES**
Uses a brace, orthotic, or another device?	☐	☐
Has special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)?	☐	☐
Wears protective eyewear, such as goggles or a face shield?	☐	☐
Wears a hearing aid or cochlear implant?	☐	☐

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

SINCE YOUR CHILD'S LAST HEALTH EXAM – HAS YOUR CHILD?

BRAIN/HEAD INJURY HISTORY	NO	YES
Has or had a hit to the head that caused headache, dizziness, nausea, or confusion, or been told they had a concussion?	☐	☐
Received treatment for a seizure disorder or epilepsy?	☐	☐
Has or had headaches with exercise?	☐	☐
Has or had migraines?	☐	☐
BREATHING	**NO**	**YES**
Complained of getting extremely tired or short of breath during exercise?	☐	☐
Used or carries an inhaler or nebulizer?	☐	☐
Has or had wheezing or coughing frequently during or after exercise?	☐	☐
Been told by a health care provider they have asthma or exercise-induced asthma?	☐	☐
DIGESTIVE (GI) HEALTH	**NO**	**YES**
Has or had stomach or other GI problems?	☐	☐
Has an eating disorder?	☐	☐
Has a special diet or need to avoid certain foods?	☐	☐
Do you have concerns about your child's weight?	☐	☐
INJURY HISTORY	**NO**	**YES**
Been unable to move their arms or legs or had tingling, numbness, or weakness after being hit or falling?	☐	☐
Had an injury, pain, or joint swelling caused them to miss practice or a game?	☐	☐
Has or had a bone, muscle, or joint that bothers them?	☐	☐
Has or had joints that become painful, swollen, warm, or red with use?	☐	☐
Been diagnosed with a stress fracture?	☐	☐
FEMALES ONLY	**NO**	**YES**
Change in period frequency related to female athlete triad?	☐	☐

Student Name:	DOB:

SINCE YOUR CHILD'S LAST HEALTH EXAM – HAS YOUR CHILD?		
MALES ONLY	**NO**	**YES**
Has only one testicle?	☐	☐
SKIN HEALTH	**NO**	**YES**
Has any rashes, pressure sores, or other skin problems?	☐	☐
Has a herpes or MRSA skin infection?	☐	☐
COVID-19 INFORMATION	**NO**	**YES**
Child tested positive for COVID-19?	☐	☐
IF NO, STOP and go to Family Heart Health History. If **YES,** answer the questions below:		
Date of positive COVID test:		
Was your child symptomatic?	☐	☐
Did your child see a healthcare provider for their COVID-19 symptoms?	☐	☐
Was your child hospitalized for COVID?	☐	☐
Was your child diagnosed with Multisystem Inflammatory Syndrome (MISC)?	☐	☐

SINCE YOUR CHILD'S LAST HEALTH EXAM – HAS YOUR CHILD?		
HEART HEALTH	**NO**	**YES**
Had a test by a health care provider for their heart (e.g., EKG, echocardiogram, stress test)?	☐	☐
Has or had lightheadedness or dizziness during or after exercise?	☐	☐
Has or had chest pain, tightness, or pressure during or after exercise?	☐	☐
Has or had fluttering in the chest, skipped heartbeats, heart racing?	☐	☐
Been told by a healthcare provider they have or had a heart or blood vessel problem?	☐	☐

If yes, check all that apply:

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

SINCE YOUR CHILD'S LAST HEALTH EXAM - CHECK ANY **NEW** FAMILY HEART HEALTH HISTORY

A relative had or is currently experiencing 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?
- ☐ Structural heart abnormality, repaired or unrepaired?
- ☐ Brugada Syndrome?
- ☐ Catecholaminergic Ventricular Tachycardia?
- ☐ Marfan Syndrome (aortic rupture)?
- ☐ Heart attack at age 50 or younger?
- ☐ Pacemaker or implanted cardiac defibrillator (ICD)?
- ☐ Known heart abnormalities or sudden death before age 50?
- ☐ 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.

☐ **Information on this form is NEW information since my child's last health examination.**

Parent/Guardian Signature:	Date:

Student Name:	DOB:

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

Parent/Guardian Signature:	Date: