MS

BEFORE You Can Tryout

Prospective Wilson Middle School student-athlete & parent:
This packet is designed to make the process of getting cleared to try out for a team as simple as possible. If you need more information, please contact the Wilson Athletic Office at 751-3200 x175.

Checklist:	☑
• The student-athlete attended the preseason informational meeting held by the coach.	☐
• The student-athlete's **NYS School Health Examination form** (Sports Physical) is current and on file in the high school clinic. *Your doctor or the school district physician can complete sports physicals.* *Sports physicals are good for one year.*	☐
• The student-athlete's **NYSED Interval Health History form** is completed no more than 30 days prior to the tryout and is on file in the high school clinic. *This form is required for every sport a student-athlete tries out for.*	☐
• The school nurse has cleared the student-athlete for participation in a **clearance email to your coach**.	☐
• Parent and athlete have read the **Wilson Athletic Policy and signed the Affidavit** agreeing to the terms of participation. Your coach will give both out once you have made the team.	☐

APP for 7th and 8th grade student-athletes trying out for a JV or Varsity team

- 7th and 8th grade student-athletes have taken and passed the **Athletic Placement Program (APP) test**. (APP Standards are in this packet)
  Once the fitness portion is passed, the student-athletes physical (with qualifying tanner score) will be sent to the district physician for approval per SED.

- If the student-athlete's tanner score is below the requirement, the **Primary Care Physician Authorization form** has been completed and is on file in the high school clinic.

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
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL			

Other Pertinent Medical Concerns
One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
☐ Concussion – Last Occurrence: _____
☐ Mental Health: _____
☐ 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:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code
_____	_____
_____	_____
_____	_____
_____	_____

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.

NYSED Interval Health History for Athletics

Two Page Form. Both pages must be completed.

Student Name:		DOB:	
School Name:		Age:	
Grade (check): ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12		Level (check): ☐ Modified ☐ Fresh ☐ JV ☐ Varsity	
Sport:		Limitations: ☐ Yes ☐ No	
Date of last health exam:		Date form completed:	

Health History To Be Completed By Parent/Guardian, Provide Details To Any Yes Answers On Back.
Any medications to be taken at practice and/or athletic event will require the proper paperwork, contact school with questions.

Has/Does your child:		
General Health Concerns	**Yes**	**No**
1. Ever been restricted by a doctor, physician assistant, or nurse practitioner from sports participation for any reason?		
2. Have an ongoing medical condition? ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Sickle Cell trait or disease ☐ Other		
3. Ever had surgery?		
4. Ever spent the night in a hospital?		
5. Been diagnosed with Mononucleosis within the last month?		
6. Have only one functioning kidney?		
7. Have a bleeding disorder?		
8. Have any problems with his/her hearing or wears hearing aid(s)?		
9. Have any problems with his/her vision or has vision in only one eye?		
10. Wear glasses or contacts?		
Allergies	**Yes**	**No**
11. Have a life threatening allergy? Check any that apply: ☐ Food ☐ Insect Bite ☐ Latex ☐ Medicine ☐ Pollen ☐ Other		
12. Carry an epinephrine auto-injector?		
Breathing (Respiratory) Health	**Yes**	**No**
13. Ever complained of getting more tired or short of breath than his/her friends during exercise?		
14. Wheeze or cough frequently during or after exercise?		
15. Ever been told by their health care provider they have asthma?		
16. Use or carry an inhaler or nebulizer?		

Has/Does your child:		
Concussion/ Head Injury History	**Yes**	**No**
17. Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told he/she had a concussion?		
18. Have you ever had a head injury or concussion?		
19. Ever had headaches with exercise?		
20. Ever had any unexplained seizures?		
21. Currently receive treatment for a seizure disorder or epilepsy?		
Devices/Accommodations	**Yes**	**No**
22. Use a brace, orthotic, or other device?		
23. Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)? If yes there may be need for another required form to be filled out.		
24. Wear protective eyewear, such as goggles or a face shield?		
Family History	**Yes**	**No**
25. Have any relative who's been diagnosed with a heart condition, such as a murmur, developed hypertrophic cardiomyopathy, Marfan Syndrome, Brugada Syndrome, right ventricular cardiomyopathy, long QT or short QT syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
Females Only	**Yes**	**No**
26. Begun having her period?		
27. Age periods began:		
28. Have regular periods?		
29. Date of last menstrual period:		
Males Only	**Yes**	**No**
30. Have only one testicle?		
31. Have groin pain or a bulge or hernia in the groin?		

NYSED Interval Health History for Athletics - Page 2

Student Name:			
School Name:		DOB:	

Has/Does your child:		
Heart Health	**Yes**	**No**
32. Ever passed out during or after exercise?		
33. Ever complained of light headedness or dizziness during or after exercise?		
34. Ever complained of chest pain, tightness or pressure during or after exercise?		
35. Ever complained of fluttering in their chest, skipped beats, or their heart racing, or does he/she have a pacemaker?		
36. Ever had a test by their medical provider for his/her heart (e.g. EKG, echocardiogram stress test)?		
37. Ever been told they have a heart condition or problem by a physician? If so, check all that apply: ☐ Heart infection ☐ Heart Murmur ☐ High Blood Pressure ☐ Low Blood Pressure ☐ High Cholesterol ☐ Kawasaki Disease ☐ Other:		
Injury History	**Yes**	**No**
38. Ever been diagnosed with a stress fracture?		

Has/Does your child:		
Injury History *continued*	**Yes**	**No**
39. Ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling?		
40. Ever had an injury, pain, or swelling of joint that caused him/her to miss practice or a game?		
41. Have a bone, muscle, or joint injury that bothers him/her?		
42. Have joints become painful, swollen, warm, or red with use?		
Skin Health	**Yes**	**No**
43. Currently have any rashes, pressure sores, or other skin problems?		
44. Have had a herpes or MRSA skin infections?		
Stomach Health	**Yes**	**No**
45. Ever become ill while exercising in hot weather?		
46. Have a special diet or have to avoid certain foods?		
47. Have to worry about his/her weight?		
48. Have stomach problems?		
49. Have you ever had an eating disorder?		

Please explain fully any question you answered yes to in the space below. (Please print clearly and provide dates if known.

Parent/Guardian Signature: _____ Date: _____

Wilson Central School District
Department of Athletics
380 Lake Street
Wilson, NY 14172
(716) 751- 9341 ext 175

2018-2019
Athletic Policy Affidavits

Parents/Guardians and student-athletes are asked to review each section and then sign and return this document to the coach. This signed affidavit must be on file in the Athletic Office in order for a student-athlete to be eligible for any sport team. The Student Handbook and Athletic Policy rules, regulations and expectations will be in effect for the student-athlete's entire career from today until graduation as a bona fide student of the Wilson Central School District. Please note that parents/guardians and student-athletes may be periodically asked to read, sign and submit a future affidavit as necessary for the Athletic Office.

Student-Athlete: _____ **Date:** _____

Anticipated Sport(s): _____ _____ _____

Assumption of Risk

As the parent/legal guardian of the student above, I hereby state that I understand that participation in sports involves rigorous physical activity and risks of physical injury. I assume these risks. I understand the inherent risks involved in participation may lead to injury or even sudden death. I hereby give consent for emergency transportation and treatment in the event of illness or injury. I give permission for my child's coach and the on-site athletic trainer to perform first aid if needed. I certify the participant is in good physical condition, and has no medical or physical conditions that should restrict his/her participation. I understand that concussion information can be found at the Wilson Athletics website.

Residency & Athletic Policy/Student Handbook

I pledge that the student-athlete is a bona fide student in the Wilson Central School District. I understand our child's role in accepting responsibility and the consequences for inappropriate actions. I understand that as an athlete our child will be held to a high standard.
I have read the Wilson Central School District Athletic Policy and Wilson Student Handbook and will support the rules as set forth.
I will also support additional rules set forth by individual coaches.

_____ _____
Parent/Guardian Signature **Student-Athlete Signature**

ATHLETIC PLACEMENT PROCESS FOR INTERSCHOOL ATHLETIC PROGRAMS

Physical Fitness: Scores
Required for the Athletic Placement Process

				Choose one[1]			Choose one[2]	
SEX	AGE	Curl-Ups # in one minute	Shuttle Run in seconds	V-sit Reach in inches	Sit & Reach in centimeters	1 Mile-Walk/Run min/sec*	Pull-Ups # completed	Right Angle Push-ups # every 3 sec.
Males	11	47	10.0	4.0	31	7:32	6	26
	12	50	9.8	4.0	31	7:11	7	30
	13	53	9.5	3.5	31	6:50	7	35
	14	56	9.1	4.5	33	6:26	10	37
	15	57	9.0	5.0	36	6:20	11	40
Females	11	42	10.5	6.5	34	9:02	3	19
	12	45	10.4	7.0	36	8:23	2	20
	13	46	10.2	7.0	38	8:13	2	21
	14	47	10.1	8.0	40	7:59	2	20
	15	48	10.0	8.0	43	8:08	2	20

PHYSICAL MATURITY CHART
Recommended Tanner Scores for the Athletic Placement Process

	MALES			FEMALES		
Approved Sports	Freshman	JV	Varsity	Freshman	JV	Varsity
Archery *	2	2	2	2	2	2
Badminton *	2	2	2	2	2	2
Baseball +	2	3	3	3	4	4
Basketball !	2	3	4	3	4	5
Bowling *	2	2	2	2	2	2
Competitive Cheerleading!	2	3	4	3	4	5
Cross-Country *	2	3	3	3	4	4
Fencing +	2	2	2	2	2	2
Field Hockey!	2	3	4	3	4	5
Football !	2	3	4	3	4	5
Golf *	2	2	2	2	2	2
Gymnastics !	2	3	3	3	4	4
Ice Hockey !	2	3	4	3	4	5
Lacrosse !	2	3	4	3	4	5
Rifle *	2	2	2	2	2	2
Skiing (Downhill) !	2	3	4	3	4	5
Soccer !	2	3	4	3	4	5
Softball +	2	3	3	3	4	4
Swim*/Diving!	2	3	3	3	4	4
Tennis *	2	3	3	3	4	4
Track & Field*	2	3	3	3	4	4
Volleyball +	2	3	3	3	4	4
Wrestling !	2	3	4	3	4	5

WorkFitMedical
COMPREHENSIVE SCHOOL HEALTH SERVICES

August 17, 2017

Dear Physician,

As of 8/15 NY State has implanted a new program in order to allow students to play up a level for sports. The full document can be found at http://www.p12.nysed.gov/ciai/pe/documents/Athletic%20Placement%20ProcessRevisedAUG2015.pdf.

Under the new guidelines students are supposed to fall under certain maturity standards based on sport in order to prevent growth plate injuries. The following is from the new guidelines:

"The medical director will clear the student to continue the APP if:

1. The student is at an appropriate physical maturity level by Tanner Scale for the desired level and sport; and
2. The student is physically comparable with the average age and sex of the students against whom the student will compete."

"Since all growth plates might not be fully matured by the time that a student reaches Tanner 5, care must be exercised in determining the physical maturity of athletes. It is always best to err on the side of caution and keep a student at the age-appropriate level of play in order to safeguard the student. "

Our policy is to follow the NY State recommendations.

Your patient does not meet the standards put out by NY State.

In order to play

Sport: _____ **Level:** _____ **Tanner Score of** _____ is recommended. Please fill out the attached form if you feel that your patient should still move up a level for sports.

Sincerely,

C. Jay Ellie, Jr. MD
School Medical Director

WorkFitMedical
COMPREHENSIVE SCHOOL HEALTH SERVICES

Primary Care Physician Authorization Form
(Must be filled out by MD/physician)

I understand the recommendation and guidelines put out by NY State for maturity level in the Athletic Placement Process. Even though my patient does not meet the recommended guidelines, after thorough evaluation and consideration, I believe that he/she is physically able to move up a level in sports play and that it is safe and in his/her best interest to do so. I hereby give my permission for my patient to be advanced.

Student Name

Sport and Level

Physician Name

Physician Signature

Date