



# Lyncourt Union Free School District

2707 Court Street, Syracuse, New York 13208

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www.lyncourtschool.org

**"Great Expectations for Achievement, Respect, and Caring"**

James J. Austin  
Superintendent

Kimberly A. Davis  
Principal

Cathryn L. Marchese  
Business Administrator

### Students interested in participating in any sport will need:

1. **PERMISSION FOR SPORTS signed by parent/guardian (below)**

2. **SPORT PHYSICAL (please check one)**

\_\_\_\_\_prefer school physician to examine child

\_\_\_\_\_prefer private physician to examine child

*\*Students may not practice, try out, or participate until the physical has been done and approved.*

### PERMISSION FOR SPORTS

Parents/Guardians:

New York State Law requires that all students taking part in interscholastic sports have a current physical and that final approval rests with the school physician.

Please indicate if any of the following conditions exist. The school physician may wish to request a report from your own physician before approving your child for sports. Any form not completely filled out and signed will be returned. \*A new form must be completed for each sport.

<u>CONDITION</u>	<u>YES</u>	<u>NO</u>	<u>DATE</u>	<u>COMMENTS</u>
Asthma	_____	_____		
Concussion	_____	_____		
Diabetes	_____	_____		
Epilepsy	_____	_____		
Rheumatic fever	_____	_____		
Recent surgery	_____	_____		
Recent serious injury	_____	_____		
Orthopedic problems (bones/muscles)	_____	_____		
Other				
*Any new problems since last permission form was signed				

My child \_\_\_\_\_ (name) has my permission to participate in

\_\_\_\_\_ (sport) after school hours at Lyncourt School.

\_\_\_\_\_  
(Parent/guardian signature)

\_\_\_\_\_  
(Date)

## STUDENT HEALTH HISTORY UPDATE

Name:	DOB:	Age:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Parent/Guardian: (person completing this form)	Grade:	Home Phone:	Date:
		Cell Phone:	

Has your child ever:	YES	NO	If Yes, please explain and include date:
Had an ongoing medical condition	<input type="checkbox"/>	<input type="checkbox"/>	
Seen a medical specialist	<input type="checkbox"/>	<input type="checkbox"/>	
Had allergies:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> food <input type="checkbox"/> environmental <input type="checkbox"/> insect <input type="checkbox"/> medication <input type="checkbox"/> other
Been hospitalized	<input type="checkbox"/>	<input type="checkbox"/>	
Had an operation	<input type="checkbox"/>	<input type="checkbox"/>	
Had an injury requiring an Emergency Room visit	<input type="checkbox"/>	<input type="checkbox"/>	
Missed 5 days of school in a row due to illness/injury	<input type="checkbox"/>	<input type="checkbox"/>	
Had a bone/muscle injury	<input type="checkbox"/>	<input type="checkbox"/>	
Passed out, had a concussion or serious head injury	<input type="checkbox"/>	<input type="checkbox"/>	
Had a convulsion/seizure	<input type="checkbox"/>	<input type="checkbox"/>	
Had a vision problem or condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> glasses <input type="checkbox"/> contacts
Had a hearing problem or condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> hearing aid <input type="checkbox"/> cochlear implant
Worn dental bridge, braces or mouthpiece	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Have any family members under the age of 50 ever:</b>	<b>YES</b>	<b>NO</b>	<b>If Yes, please specify:</b>
Had a heart attack	<input type="checkbox"/>	<input type="checkbox"/>	
Had other serious health problems	<input type="checkbox"/>	<input type="checkbox"/>	

**CHECK ALL THAT APPLY TO YOUR CHILD:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> ADHD<br><input type="checkbox"/> Asthma/trouble breathing<br><input type="checkbox"/> Autism/Asperger<br><input type="checkbox"/> Dental Injuries<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Ear Infections | <input type="checkbox"/> GI Conditions (ulcer, reflux, IBS)<br><input type="checkbox"/> Headaches/migraines<br><input type="checkbox"/> Heart Conditions<br><input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> Mental Health Condition<br>(depression, eating disorder, anxiety, OCD, ODD, etc.) | <input type="checkbox"/> Scoliosis<br><input type="checkbox"/> Single Organ ( <input type="checkbox"/> kidney, <input type="checkbox"/> testicle)<br><input type="checkbox"/> Skin Condition<br><input type="checkbox"/> Speech Condition<br><input type="checkbox"/> Urinary Condition |
|--|--|---|

CURRENT MEDICATIONS	YES	NO	Please list name, dose, time(s)
Given at school	<input type="checkbox"/>	<input type="checkbox"/>	
Taken at home	<input type="checkbox"/>	<input type="checkbox"/>	
ASSISTIVE EQUIPMENT	YES	NO	Please check all that apply
During or outside of school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> crutches <input type="checkbox"/> walker <input type="checkbox"/> wheelchair <input type="checkbox"/> other:
TREATMENTS	YES	NO	
During or outside of school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> insulin/blood glucose monitoring <input type="checkbox"/> inhaler/nebulizer/peak flow monitoring <input type="checkbox"/> special diet

Is there any condition that would prevent your child from participating in physical education or sports?

No  Yes: \_\_\_\_\_

Please list any additional concerns: (use back of sheet if necessary) \_\_\_\_\_

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