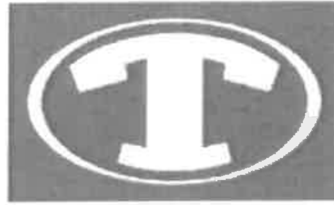


TO: Fall Athletes and Parents (Varsity, JV and Modified)

FROM: Robert Sutphen, Athletic Director

RE: Athletic Clearance – Fall Sports Ticonderoga School District
****

Physical exams for all athletes for the 2022-23 school year were completed throughout the prior school year and completed in the spring of 2022. However, many of those physical exams are incomplete as the student failed to return a signed Health History form before the physical. No student will be cleared to participate in try-outs without a completed, Health History form, Health Update form and physical exam. If for any reason you did not have a physical exam this spring or to answer any other questions, please contact Mr. Sutphen at 585-7400 ext. 1159 or by email rsutphen@ticonderogak12.org.

The enclosed Health History form and the Update form must be completed and turned in to the nurse for medical clearance at the dates and times specified below. The forms can be found on the Ticonderoga High School web page and are available in the main office at the High School. Practice schedules will be posted the day you turn in your forms. You will not be able to practice until these forms have been completed and the nurse has cleared you.

If you have any questions about pre-season practices please contact your head coach.

The dates and times set up for medical clearance are as follows:

Thursday, August 18, 2022 @ the JR/SR High School Nurse's office
8:00 a.m. – Varsity Football
8:15 a.m. – Modified Football
8:30 a.m. – Varsity Soccer
8:45 a.m. – JV Soccer
9:00 a.m. – Modified Soccer
9:15 a.m. – Varsity Cross Country
9:30 a.m. – Modified Cross Country

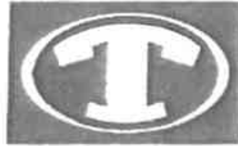
If any athlete missed the Thursday date or did not have the proper paperwork, the nurse will be available from 8:00 a.m. – 9:00 a.m. on **Friday, August 19, 2022 and on Friday, August 26, 2022** for any modified player who missed the first two dates.

JV and Varsity sports will start practice on Monday, August 22, 2022 and modified sports will start on Monday, August 29th, with the exception of Varsity Football, which will start August 20th. The full time, date and practice location will be available at the medical clearance date.

RS/rm

TICONDEROGA CENTRAL SCHOOL

Sports Update



Prior to the start of tryout sessions or practice at the beginning of ***each season***, a Sports Update form for each athlete must be conducted unless the student received a full medical examination within 30 days of the start of the season.

TO BE COMPLETED BY PARENT OR GUARDIAN

STUDENT: ____ AGE: _________

GRADE: ______________________________ BIRTHDATE: ________________________

SPORT: ____

If the answer to any of the following questions is "YES", please describe on the reverse side of this form the condition or situation that prompted your answer.

NOTE: "YES" to any of the questions below does not mean automatic disqualification from the athletic activity. However, it will require a review and approval by the school physician before the student can report to practice or tryouts.

The answers to the questions on this form will be held in the school health office and will be kept confidential.

Since his/her **LAST** sports physical, has your child had:

1. Any injuries requiring medical attention? ____Yes ____ No
2. Any illness lasting more than (5) days? ____ Yes ____ No
3. Taking medicine or under physician's care at this time? ____ Yes ____ No
4. Any feeling of faintness, dizziness, or fatigue after exercise or Exertion? ____ Yes ____ No
5. Change in wearing glasses or contact lenses? ____ Yes ____ No
6. Any surgical operations or fractures? ____ Yes ____ No
7. Any treatment in a hospital or emergency room? ____ Yes ____ No
8. Developed any allergies? ____ Yes ____ No
9. Any chronic disease? ____ Yes ____ No

Describe the condition or situation that caused any questions to be answered "YES" on the front:

____

____

____

____

____

____

PARENTAL PERMISSION:

I, the undersigned, clearly understand these questions are asked in order to decide if your child can safely participate on the athletic team. The answers are correct as of this date and he/she has my permission to participate.

PARENT/GUARDIAN SIGNATURE: ______________________________ DATE: __________

PLEASE RETURN TO THE SCHOOL HEALTH OFFICE

TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE

Date of Last Appraisal: ____________________ Limitations? ____ Yes ____ No

Sports Participation: _______ Approved _______ Referred to School Physician

Signature: ______________________________________ Date: ____________
(School Health Office)

If referred to the School Physician:

Re-Qualified: _________ Disqualified: _________

Physician Comments:

____

____

____

____

____

____

Signature: ______________________________________ Date: ____________
(School Physician)

Ticonderoga Central School	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:		
Have Allergies?	☐	☐
If yes, check all that apply ☐ Food ☐ Insect Bite ☐ Latex ☐ Medicine ☐ Pollen ☐ Other:		
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	**No**	**Yes**
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
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ New fast or slow heart rate
- ☐ Heart infection
- ☐ Heart Murmur
- ☐ Low Blood Pressure
- ☐ 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: