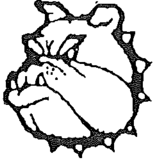
KENMORE EAST
HIGH SCHOOL



KENMORE-TOWN OF TONAWANDA UNION FREE SCHOOL DISTRICT
DEPARTMENT OF PHYSICAL EDUCATION, RECREATION AND ATHLETICS
1500 Colvin Boulevard
Buffalo, New York 14223-1196
Telephone: (716) 874-8411, Ext. 4
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BRETT A. BANKER
Supervisor

TERRY BAUMGARDNER
Secretary

KENMORE WEST
HIGH SCHOOL

EDISON ELEMENTARY SCHOOL
FRANKLIN ELEMENTARY SCHOOL
HAMILTON ELEMENTARY SCHOOL
HOLMES ELEMENTARY SCHOOL
ROOSEVELT ELEMENTARY SCHOOL
LINDBERGH ELEMENTARY SCHOOL
JEFFERSON ELEMENTARY SCHOOL
HOOVER ELEMENTARY SCHOOL

STUDENT'S NAME:________________________ SPORT:____________________

Dear Student-Athlete, Parents/Guardians:

The New York State Public High School Athletic Association **requires** each student-athlete to have a current athletic physical on file during their season(s) of competition. The Kenmore-Town of Tonawanda School District is in full compliance with this policy and students will not participate without one. We will accept two types of athletic physical.

I. Appraisals completed by your family physician

Family physicians must still use our district's Athletic Health History Form, a two-sided yellow document. These physicals are done at your expense and your family is responsible for making the appointment, picking up the proper form and making sure the physician's office completes the form as required. Your completed form must be returned to your school nurse.

Our forms are available in the Health Office of each school

II. Appraisals completed by the district's Medical Team

If you choose this option you must sign below and return this form to your school nurse. Student-Athletes are required to be proactive and listen to announcements regarding signing up for a physical at school. The opportunity for a district physical is limited and appointments must be made and kept. These appraisals are free to district student-athletes.

District organized examinations are complete physicals which will include tests to evaluate a student-athlete's blood pressure, presence of any hernia and impairments in their vision. For safety, personal health and also to assist in decreasing the number of injuries your athlete may experience, another portion of the examination will consider the level of physical maturity. This evaluation may involve an examination of secondary sexual characteristics such as start of menstruation and pubic hair growth. These findings correlate well and assist us in determining muscle size and strength as well as bone development.

X____ X______________

The parent signature affixed above provides consent for a physical examination by Ken-Ton Medical/Health professionals — *Date*

We are hopeful that these options assist you in meeting both New York State and Ken-Ton's physical examination requirements for participation in athletics. If you have any questions please contact my office or the Health Office at your school.

Yours in Sports,

Brett A. Banker
Supervisor of Physical Education, Recreation & Athletics

FRANKLIN MIDDLE SCHOOL HOOVER MIDDLE SCHOOL KENMORE MIDDLE SCHOOL

Health History

Parents must complete this side

Kenmore-Town of Tonawanda UFSD
1500 Colvin Boulevard
Buffalo, NY 14223

Name of Student ______________________ Age ______ Date of Birth ______________

Sport ______________ School ______________ Gender ________ Grade ______

*** For the students completing a sport physical:**
The Health History and Health Appraisal (reverse side) must be completes within 12 months **BEFORE** sports participation and tryouts. (The Health History must be completed before the student has his/her physical).
Students **MUST** pick up and return **ALL** forms to the Health Office.
DO NOT TURN INTO THE COACH.

Part A – Health History: To be completed by Parent/Guardian.

Has your child ever had, or currently has, any of the following: (please check) *Fill in below if YES.

	Yes	No	Date
1. Elevated blood pressure	☐	☐	______
2. Heart Problem/Murmur/chest pains	☐	☐	______
3. Allergies/hay fever (type) ______	☐	☐	______
4. Insect sting allergy (type) ______	☐	☐	______
5. Asthma	☐	☐	______
6. Diabetes/hypoglycemia	☐	☐	______
7. Injury to spleen	☐	☐	______
8. Heat exhaustion/stroke, other	☐	☐	______
9. Joint sprains/ligament tear, muscle	☐	☐	______

	Yes	No	Date
10. Back problem	☐	☐	______
11. Knee problem	☐	☐	______
12. Ankle problem	☐	☐	______
13. Headaches/dizziness	☐	☐	______
14. Head injury/concussion	☐	☐	______
15. Loss of consciousness due to injury	☐	☐	______
16. Neck injury	☐	☐	______
17. Convulsions/seizures	☐	☐	______
18. Hernia	☐	☐	______

	Yes	No	Date
1. Within the last 12 months has your child had an illness that:			
a. required hospitalization?	☐	☐	______
b. lasted longer than a week?	☐	☐	______
c. caused missing 5 days of practice or competition?	☐	☐	______
d. required surgery for (explain) ______	☐	☐	______
2. Within the last 12 months has your child had an injury that:			
a. required going to the emergency room or to see a doctor?	☐	☐	______
b. required hospitalization?	☐	☐	______
c. required x-rays?	☐	☐	______
d. caused missing 5 days of practice?	☐	☐	______

	Yes	No	Date
3. Does your child take any medication now? (list) ______	☐	☐	______
Any long term medications? list) ______	☐	☐	______
4. Does your child wear (circle which)			
a. glasses/contacts	☐	☐	______
b. dental bridges, plates/braces, special pads, protective equipment	☐	☐	______
5. Is your child missing one of any paired organs? (circle one) eye, kidney, testicle, ovary	☐	☐	______
6. Has there ever been sudden death in the family of a person under 50 yrs of age? (explain) ______	☐	☐	______

7. FOR WOMEN: Fill in the following
a. Age at first menstrual period ______
b. How often period occurs ______
c. When was last period? ______

***YES ANSWERS MUST PROVIDE EXPLANATION FOR APPROVAL TO PARTICIPATE.** (Explain) ______________________
____
____
____
____

AFFIRMATION: I affirm that the preceding statements are true and correct, and I consent to the participation of my child in the interscholastic program of his/her school, including practice sessions and travel to-and-from the athletic contests; I agree to emergency medical treatment for my child, as deemed necessary by the physician designated by school authorities; I give my permission for the school nurse to share any pertinent health information regarding my child with school and emergency personnel on a need-to-know basis. Signature implies consent for school physical if needed.

Signature of Parent/Guardian: ______________________ Date: ____________
Emergency Telephone: ______________ Cell Phone: ______________
Home Address: ______________________ Work Phone: ______________
Private Physician: ______________________ Private Physician Telephone: ______________

Health Appraisal/Sports

(use black ink only)

To be completed by
PHYSICIAN ONLY

Kenmore-Town of Tonawanda UFSD
Student Services / Health Services

Name of Student ______________________________

IMMUNIZATIONS / SCREENINGS
(Check one and record below)
☐ No immunizations /screenings given today
☐ Given since last exam
☐ Record attached

Dates and vaccines given within the last year:

____
____
____
____

Vision/Hearing

Vision without:	☐ glasses ☐ contact lenses	R	L
Vision with:	☐ glasses ☐ contact lenses	R	L
Vision:	Near Point	R	L
Hearing:	☐ Screening ☐ Audiogram	R	L
	Tympanogram	R	L

MEDICAL HISTORY
Significant medical/ surgical history: ______________________________
Allergies: ______________________________
Medications taken regularly: ______________________________

PHYSICAL EXAMINATION
Height: __________ Weight: __________ BP: _____/_____ Resting Pulse: __________ Fe LMP: __________

	Normal	Abnormal
General appearance		
Nutrition		
Skin		
Head		
Eyes		
Ears		
Nose/Throat		
Teeth		

	Normal	Abnormal
Neck: nodes/thyroid		
Lungs		
Heart		
Abdomen		
Genitalia		
Musculoskeletal		
Scoliosis	☐ Neg	☐ Pos
Neurological		

Comments
Scale 1-5: 1=Cachetic 3=WNL 5=Obese

BMI: **BMI %:**

Tanner Stage – Must be completed for student to play sport
☐ I ☐ II ☐ III ☐ IV ☐ V

Missing organs: Eye, Kidney, Gonad

☐ No Medication ☐ Medication at home only ☐ Medication to be given at school

Name, route, dosage, frequency, time: ______________________________

If morning does is missed at home: ______________________________

Student is "self-directed" ☐ Yes ☐ No *Self-directed: Student knows use and purpose of medication, route, dosage, and frequency of administration.*
Student may carry MDI: ☐ In school ☐ On Field Trips *Student is capable of self-administration of medication with adult supervision; may carry MDI.*

Parent/Guardian name (print) ____________________ Parent/Guardian signature ____________________

SPORTS: Student is physically qualified for participation in sports and school activities as indicated below:
☐ Contact/Collision: Baseball, Basketball, Diving, Field hockey, Football, Ice hockey, Jumping, Lacrosse, Soccer, Softball, Wrestling
☐ Non-Contact/Strenuous: Cheerleading, Cross-country, Field hockey, Gymnastics, Running, Track & Field, Volleyball, Swimming
☐ Non-Strenuous: Bowling, Golf, Rifle
☐ Knowledge-based experience only

Protective Equipment: ☐ Athletic cup ☐ Chest pad ☐ Glasses/ eye wear ☐ Helmet ☐ Joint pads ☐ Mouth guard ☐ Wrist guards

EMPLOYMENT: ☐ Student is physically qualified for employment ☐ Known or suspected disability: ____________________
☐ Restrictions ______________________________

Provider name (please print) ____________________ Telephone # __________ Fax # __________

Provider signature ____________________
Date of exam ____________________

Update Athletic Health History
for Sports Participation

Kenmore-Town of Tonawanda UFSD
1500 Colvin Boulevard
Buffalo, NY 14223

School: ☐ KE ☐ KW ☐ FMS ☐ HMS ☐ KMS

Prior to the start of tryout sessions or practice at the beginning of each season, a health history review for each athlete must be conducted, unless the student received a full medical examination with 30 days of the start of the season.

Please use black or blue ink only.

Name of Student ______________________ Grade ______ Date of Birth ____________

Sport ______________________ Level: ☐ Varsity ☐ JV ☐ Frosh ☐ Modified

To be completed by Parent/Guardian

Note: "Yes" to any of the following questions does not mean automatic disqualification from the athletic activity indicated above. However, it will require a review and approval by the school examiner 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. Coaches will be informed of any significant medical information.

History Since Last Health Appraisal

If the answer to any of the following questions is Yes, please describe the condition or situation that prompted your answer.

	Yes	No
Has your child had any injuries requiring medical attention?	☐	☐
Has your child had any illness lasting more than five (5) consecutive days?	☐	☐
Is your child taking medicine or under a physician's care at this time?	☐	☐
Has your child experienced any feeling of faintness, dizziness or fatigue after exercise or exertion?	☐	☐
Has there been a change regarding the wearing of glasses or contact lenses?	☐	☐
Has your child had any surgical operations or fractures?	☐	☐
Has your child received treatment in a hospital or emergency room?	☐	☐
Has your child developed any allergies?	☐	☐
Does your child have any chronic disease?	☐	☐

(Use the space below to explain any "Yes" answers.)

____

____

____

Parental Permission

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

Signature of Parent/Guardian ______________________ Date ____________

Please fill in completely, sign, and return to School Health Office

(1/04) 7.10b

This side to be completed by the school health office

Sports Participation:

☐ Approved ☐ Referred to School Examiner

Signed: ____

If referred to the School Examiner:

☐ Requalified ☐ Disqualified

Signature of School Examiner: ______________________________

Date of last Health Appraisal ______________________________

Limitations: ☐ Yes ☐ No

Athlete's Name: ______________________________ Date: __________________________

Athlete's Date of Birth: ________________________ Grade: _________________________

Athlete's School: ______________________________ List Sport(s):
Fall: ____________________
Winter: __________________
Spring: __________________

Kenmore-Tonawanda School District contracts a Certified Athletic Trainer (ATC) through AthletiCare of Catholic Health, for coverage of school athletics. This Certified Athletic Trainer is qualified to assess, treat and recondition most injuries your son or daughter may incur while participating in the school's athletic programs.

The Certified Athletic Trainer's qualifications include: certification by the National Athletic Trainers Association, registration/licensure with the New York State Education Department, certification in CPR for the Professional Rescuer and First Aid, and a minimum of a Bachelor of Science degree in the Sports Medicine field.

I give my permission for the Certified Athletic Trainer to assess, treat and/or recondition my son or daughter.

__________________________________ Parent/Guardian's Signature

__________________________________ Printed Name

Address: ___________________________

____

Evening Phone # (After 5pm): _______________

Daytime Phone # : ______________________

*****Please return to the school nurse or coach with completed physical card*****