



STUDENT-ATHLETE CHECKLIST OF REQUIREMENTS FOR ATHLETIC ELIGIBILITY

- () **Athletic Department Permission Form** – Form must be completed, signed, and returned to the Main Office for each sport season.

- () **Spectator Code of Conduct Form** – Form must be signed by parents/guardians of student-athlete and returned to the Main Office.

- () **Health History Form** – Form must be completed, signed, and returned to the school nurse for medical clearance. The Initial Health History form must be turned in for the first sport season the student plays in. If the student participates in additional seasons, the Interval Health History form must be turned in to the nurse's office. A Health History form must be turned in for each individual sport season.

- () **Health Appraisal (Physical) Form** – An up-to-date annual physical exam must be on file in the Health Office. The physical must be from within one year of the start of the current sport season.

**STUDENTS WILL NOT BE ELIGIBLE FOR PARTICIPATION
IN BG ATHLETICS WITHOUT FULFILLING ALL OF THE ABOVE
REQUIREMENTS.**



BISHOP GRIMES ATHLETICS

2018-2019 ATHLETIC PERMISSION FORM

(Form must be filled out and returned to Main Office for each sport season.)

Dear Parents/Guardians,

If you wish your student to participate in an athletic activity sponsored by the school, it is necessary that you sign this permission form and return it to the Athletic Director. Student-athletes will not be allowed to participate in Bishop Grimes athletics unless a signed permission form has been returned and have been cleared through the Health Office. Please use a separate form for each student in your family. Once this form has been signed and returned, it will be assumed that permission has been granted for your student to participate **in that specific sport and related activities**. Also, the name of your insurance coverage should be included on this form.

Date _____ Grade _____ Sport _____

I grant permission for my student (name) _____
to participate in the above activity sponsored by the school unless otherwise noted by me in writing. I also understand that my own insurance must cover any injuries that occur during participation in the Bishop Grimes athletic program.

The name of my insurance company is:

I have read and understand the Athletic Department's rules and regulations and agree to abide by and be held accountable to those rules and regulations as long as I am a participant in the Bishop Grimes athletic program.

Signature & Name of Student-Athlete

Student-Athlete Signature

Student-Athlete Name (Please print.)

Signature & Name of Parent(s) or Guardian(s)

Parent/Guardian Signature

Parent/Guardian Signature

Parent/Guardian Name (Please print.)

Parent/Guardian Name (Please print.)

Home Phone Number _____

Emergency Phone Number _____

Bishop Grimes Athletic Department

2018-2019 Rules and Policies for all Student-Athletes

An athlete at Bishop Grimes is, first and foremost, a Christian and should be constantly guided by Christian values and principles. These values shall not be compromised for the sake of winning.

1. Alcoholic beverages, tobacco products, electronic cigarettes and vaping products (including Juul), performance enhancing drugs, and ANY other illegal drugs are prohibited. The use of these substances during a sport season may be grounds for dismissal from a team and Bishop Grimes upon review by the school's administration.
2. A student-athlete under any type of school-imposed suspension (including In School Suspension) cannot attend practice or participate in contests until the day following the expiration of such suspension. The student-athlete is subject to suspension or dismissal from a team for knowingly violating school rules upon review by the school's administration.
3. In order to participate in either practices or contests on that day, a student-athlete must be in school **no later than 8:30 a.m.** and must remain in school until their final scheduled class legally excused. Seniors may **not** use their early dismissal privilege unless their practice or contest begins on or after 4:30 that day, or if they have received permission from a school administrator.
4. Any student-athlete who is dismissed from a team will have his/her parent(s)/guardian(s) notified of the reason for dismissal and may request a meeting with the appropriate coaches and school administrators. A meeting will be **required** before the student-athlete is allowed to participate in another sport. The same policy is required of any student-athlete who chooses to quit participating on a team after the official roster has been selected. A school administrator will conduct such a meeting.
5. A student-athlete is responsible for all equipment issued and must pay for any lost or damaged equipment. It is the responsibility of the student-athlete to return any school-owned game uniforms or equipment immediately after the final contest of the season. Failure to do so will prevent the student-athlete from participating in another sport.
6. All athletes must travel to and from athletic contests under the supervision of the coach. Direct parental permission given to the coach **in writing** may enable student-athletes to leave game sites with parents based on individual team policies.
7. All student-athletes must complete and return the following items in order to be eligible for participation in a sport:
 - A.) An Up-To-Date Health Appraisal (Physical) Form**, which should be turned into and approved by the school's nurse. The physical must be from within one year of the start of the current sport season.
 - B.) An updated Health History Form**, which needs to be turned in at the beginning of each sport season. This is mandated by our home school district (East Syracuse-Minoa) and by New York State.
 - C.) A signed Athletic Permission Form**, which implies parental/guardian consent for participation and student-athlete understanding of rules and regulations.
 - D.) A signed Spectator Code of Conduct** from parents/guardians.
8. The violation of any of the above rules, or any individual team-specific rules stated in advance by the head coach, may result in suspension or dismissal from a team or program at the discretion of school's administration in addition to other discipline if deemed necessary by the administration.



2018-2019 BISHOP GRIMES ATHLETIC DEPARTMENT SPECTATOR CODE OF CONDUCT

Name of Student-Athlete _____

Season / Sport _____ Date _____

Please understand that parents/guardians, family members, etc. should not expect to discuss playing time with members of the Bishop Grimes coaching staff. Those conversations should be between the student-athlete and the coach only.

If there is a perceived problem other than playing time, the following is the appropriate conflict resolution path:

- (a) Student-Athlete talks with coach. If problem is not resolved...
- (b) Student-Athlete brings the Athletic Director into the matter. If problem is still not resolved...
- (c) A meeting can be arranged that will include the Student-Athlete, Coach, School Administration, and Parent(s).

Bishop Grimes expects all of our spectators and fans to abide by the following policies and practices:

1. I will remember that an essential component of high school athletics is for student-athletes to have fun, develop friendships, learn strategies, and work with peers toward team goals.
2. I will allow the coaches to do all instructing in all practice and game settings. I will not try to coach my student, or any others, from the sidelines or stands. It is important that the coaches be the instructional leaders in all cases.
3. I will represent Bishop Grimes with the best possible sportsmanship at all events. I will not single out any players, coaches, officials, or game staff. I will accept the judgments of all coaches and officials at games and practices.
4. At home events, I will display courtesy and hospitality to any visiting players or spectators. At away events, I will act appropriately in representation of Bishop Grimes.
5. I will not use social media as a forum to make comments on players, coaches, opposing schools or their spectators.
6. I will not confront officials or coaches immediately before, during, or immediately after games.
7. I will not use any language or make comments that can be construed as derogatory or offensive by anyone who is participating, working, or watching a practice or game.
8. I will encourage and cheer for all members of my student-athlete's team.
9. I will not use drugs, tobacco, e-cigarettes or vaping devices (including a Juul), or alcohol on or near any school grounds, and I will not attend an event under the influence of any drugs or alcohol.
10. I understand that Bishop Grimes has adopted a ZERO TOLERANCE POLICY and agree that failure to abide by any of the aforementioned guidelines can result in the following:

For minor incidents: Warning by staff and/or school administration that conduct is approaching an inappropriate level.

A First Offense will result in a minimum of removal from that event plus suspension of privileges from the next scheduled contest for that team or program.

A Second Offense will result in a minimum suspension of attendance privileges for any event on school grounds for a 12-month period.

After a 12-month ban, a hearing may be held to review the possibility of attendance privileges being reinstated. The hearing will include at least the school Principal.

Signature & Name of Parent(s) or Guardian(s)

Parent/Guardian Name

Parent/Guardian Signature

Parent/Guardian Name

Parent/Guardian Signature

Health History / Physical Evaluation

The Health History is to be completed for all students by the parent.

Name _____	Sex _____	Age _____
Date of Birth _____	Phone _____	Grade _____ School _____

Explain "Yes" answers at the bottom of this form.

	YES	NO
1. Has your child had a medical illness or injury since their last check up or physical?		
Does your child have an ongoing or chronic illness? (for example, Diabetes, Kidney Disease)		
Does your child have a bleeding tendency? (For example, severe or frequent nosebleeds, dysmenorrhea?)		
Has your child ever had or have jaundice?		
Has your child ever had tuberculosis or a positive skin test for any reason?		
2. Is your child missing one of a paired organ or the function of one of a paired organ? (ie: Eye, Kidney, Lung, Testicle)		
3. Has your child ever been hospitalized overnight?		
Has your child ever had surgery?		
4. Is your child currently taking any prescription or non-prescription (over-the-counter) medications or using an inhaler?		
Has your child ever taken any supplements or vitamins to help them gain or lose weight or improve their performance?		
5. Does your child have any allergies (for example, to pollen, medicine, food, latex or stinging insects)? <i>Please explain all allergies, including medication information, in detail, below.</i>		
6. Has your child ever passed out or been dizzy during or after exercise?		
Has your child ever had chest pains during or after exercise?		
Does your child get tired more quickly than their friends do during exercise?		
Has your child ever had their heart race or skip heartbeats?		
Has your child had high blood pressure or high cholesterol?		
Has your child ever been told they have a heart murmur?		
Has your child had a family member or relative died of heart problems or of sudden death before age 50?		
Has your child had a severe viral infection (for ex: myocarditis or mononucleosis) within the last month?		
Has your child's physician ever denied or restricted their participation in any activity or sports for any heart problems?		
7. Does your child have any current skin problems - for example, itching, rashes, acne, warts, fungus or blisters?		
8. Has your child ever had a head injury or concussion?		
Has your child ever been knocked out, become unconscious, or lost their memory?		
Has your child ever had a seizure?		
Does your child have frequent or severe headaches?		
Has your child ever had numbness or tingling in their arms, hands, legs, or feet?		
Has your child ever had a stinger, burner, or pinched nerve?		
9. Has your child ever become ill from exercising in the heat?		
10. Does your child cough, wheeze, or have trouble breathing during or after activity?		
Does your child have asthma?		
Does your child have seasonal allergies that require medical treatment?		
11. Does your child have to use any special protective or corrective equipment or devices that are not usually used for regular physical activity, sports or position (for example, knee brace, special neck roll, foot orthotics, retainer on their teeth, hearing aid)?		
12. Has your child had any problems with their eyes or vision?		
Does your child wear glasses, contact lenses or protective eyewear?		
13. Does your child have any difficulty hearing?		
14. Has your child ever had a sprain, strain or swelling after injury?		
Has your child ever broken or fractured any bones or dislocated any joints?		
Has your child had any other problems with pain or swelling in muscles, bones, or joints?		

If **yes**, check appropriate box and explain below:

	Ankle		Chest		Foot		Knee		Shoulder
	Arm		Elbow		Hand		Neck		Thigh
	Back		Finger		Head		Shin / Calf		Wrist

Please explain those injuries:

15. Does your child want to weigh more or less than they do now?		
Does your child lose weight regularly to meet weight requirements for their sport?		
16. Does your child feel stressed out?		

Explain 'YES' answers to all questions here:

QUESTION # 17 IS FOR FEMALE JUNIOR AND SENIOR HIGH SCHOOL STUDENT ONLY

When was your most recent period? (date)		
How many days do you usually have from the start of one period to the start of another?		
How many periods have you had in the last year?		
What was the longest time between your periods in the last year?		

A current tetanus shot (one received within the last ten years) is required for participation in all Interscholastic Sports.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of student _____ Date _____

Signature of parent/guardian _____ Date _____

**EAST SYRACUSE MINOA SCHOOLS
HEALTH APPRAISAL FORM ***

Name _____ Gr _____ Date of Exam _____

Date of Birth _____ Gender: Male Female

IMMUNIZATION / HEALTH HISTORY	
<input type="checkbox"/> Immunization record attached <input type="checkbox"/> No immunizations given today <input type="checkbox"/> Immunizations given since last Health Appraisal:	PPD: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done Date: _____ Blood Lead Test _____ mcg/dL <input type="checkbox"/> Not done Date: _____ Dental Referral: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done Date: _____

Specify current and chronic disease: Asthma Diabetes: Type 1 Type 2 Hyperlipidemia Hypertension
 Single organ _____ Other _____

Allergies: **LIFE THREATENING** Food: _____ Insect: _____ Other _____
 Seasonal Medication: _____

PHYSICAL EXAMINATION											
Height: _____ Weight: _____	Blood pressure: _____ / _____	BP Re check: _____ / _____	Pulse: _____								
Body Mass Index: _____ - _____ % Weight Status Category (BMI Percentile): <input type="checkbox"/> less than 5 th <input type="checkbox"/> 5 th through 49 th <input type="checkbox"/> 50 th through 84 th <input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th and higher		Vision and Hearing Screening <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">Vision- without / with glasses/contact lenses</th> <th style="width: 12.5%;">R 20/</th> <th style="width: 12.5%;">L 20/</th> <th style="width: 50%;">Referral</th> </tr> </thead> <tbody> <tr> <td>Hearing</td> <td>R dB</td> <td>L dB</td> <td></td> </tr> </tbody> </table>		Vision- without / with glasses/contact lenses	R 20/	L 20/	Referral	Hearing	R dB	L dB	
Vision- without / with glasses/contact lenses	R 20/	L 20/	Referral								
Hearing	R dB	L dB									

Eyes	<input type="checkbox"/> PERRLA <input type="checkbox"/> EOMI <input type="checkbox"/>	Neck	<input type="checkbox"/> No Thyromegaly <input type="checkbox"/>	Scoliosis	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/>
Ears	<input type="checkbox"/> TM's NI landmarks <input type="checkbox"/> Not examined <input type="checkbox"/>	Heart	<input type="checkbox"/> w/o Murmur <input type="checkbox"/> Regular <input type="checkbox"/>	Extremities	<input type="checkbox"/> NI gait <input type="checkbox"/> Full ROM <input type="checkbox"/> No C/C/E <input type="checkbox"/>
Nose	<input type="checkbox"/> NI mucosa <input type="checkbox"/> w/o bleeding <input type="checkbox"/>	Lungs	<input type="checkbox"/> CTA <input type="checkbox"/>	Skin	<input type="checkbox"/> w/o suspicious lesions <input type="checkbox"/> Acne <input type="checkbox"/>
Teeth	<input type="checkbox"/> w/o caries <input type="checkbox"/> Good Repair <input type="checkbox"/>	Abdomen	<input type="checkbox"/> w/o Guard <input type="checkbox"/> w/o Mass, Benign <input type="checkbox"/>	Maturation (if applicable)	<input type="checkbox"/> Age of Menarche _____ <input type="checkbox"/> Tanner Stage-I II III IV V
Tonsils	<input type="checkbox"/> w/o exudates <input type="checkbox"/> w/o redness <input type="checkbox"/>	Hernia	<input type="checkbox"/> None <input type="checkbox"/> Not examined <input type="checkbox"/>	Other	
Lymph	<input type="checkbox"/> w/o LA <input type="checkbox"/> Not Examined <input type="checkbox"/>	Genitalia	<input type="checkbox"/> Normal <input type="checkbox"/> N/A <input type="checkbox"/> N/A - USPSTF*		

MEDICATION INFORMATION

List all NEW medications and the dosages for this student (This is NOT an order for medication use in school.):

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

PHYSICAL EDUCATION: Full Physical Activity Modified Physical Activity _____

Physically qualified for all interscholastic sports, intramural and extramural activities and full playground activities OR only as checked below:

- Contact / Collisions:** Basketball, Diving, Football, Hockey, Lacrosse, Martial Arts, Soccer, Wrestling
- Limited Contact:** Baseball, Bicycling, Cheerleading, Field (High Jump and Pole Vault), Floor Hockey, Gymnastics, Handball, Horseback Riding, Racquetball, Skating, Skiing, Softball, Squash, Ultimate Frisbee, Volleyball.
- Non-contact:** Archery, Badminton, Body Building, Canoeing, Cross Country, Dancing, Field (Discus, Javelin, Shot Put), Golf, Rope Jumping, Running, Scuba Diving, Strength Training, Swimming, Table Tennis, Track, Walking, Weight Lifting.

WORKING Physically qualified for lawful employment.

PAPERS: Physically qualified for limited employment due to a disability. Specify accommodation _____

Specify medical accommodations needed for school: _____ None

Known or suspected disability: _____ Please monitor

Restrictions: _____ Please monitor

Protective equipment required: Athletic Cup Sport goggles/impact resistant eyewear Other _____

(Stamp Below)

Provider's Signature: _____ Phone: _____

Provider's Name / Address: _____ Fax: _____

*The USPSTF publishes guidelines for complete physical exams. These are the best evidence available and can be obtained from www.ahrq.gov/clinic/upstfix.html

BISHOP GRIMES JR/SR HIGH SCHOOL

Interval Health History for Athletic Participation

This form must be submitted to the school nurse and
dated no sooner than 30 days before the first day of practice.

Parent/Guardian must complete this form

Part A :

Student Name: _____ Age: _____ DOB: _____ Grade(circle): 7 8 9 10 11 12

Sport: _____ Level (circle): Varsity JV Modified

HISTORY SINCE LAST PHYSICAL EXAMINATION:

Last Physical Date: _____ Tetanus Date: _____

- | | YES | NO |
|--|-----|-----|
| 1) Since your child's last physical examination, has your child had any injuries requiring medical attention?* | [] | [] |
| 2) Since your child's last physical examination, has your child had any injury or illness lasting more than five (5) days?* | [] | [] |
| 3) Since your child's last physical examination, has your child had any feeling of faintness, dizziness or fatigue after exercise or exertion?* | [] | [] |
| 4) Since your child's last physical examination, has your child had any serious illness, injury, surgical operations or fractures?*(ie: Mono, meningitis, pneumonia, etc.) | [] | [] |
| 5) Does your child have any allergies (insect, medicine, food)? | [] | [] |
| 6) Is your child taking medicine or under a provider's care for a current medical problem or condition? | [] | [] |
| 7) Does your child wear glasses or contact lenses? | [] | [] |
| 8) In the last 12 months, has your child sustained a concussion or suffered from "concussion-like" symptoms? If yes, please describe below | [] | [] |

NOTE: Checking "YES" to the questions that are marked with an * will require a release from your child's health care provider regardless of whether or not any restrictions were placed on athletic participation. This detailed note should indicate the nature of the illness, injury or surgery, the date of the office visit and the date that he/she may resume participation.

Part B - Describe the condition or situation that caused any questions in Part A to be answered "Yes".

Part C - I, the undersigned, clearly understand these questions are asked in order to decide if my child can safely participate on the Bishop Grimes athletic team named in Part A of this form. The answers are correct as of this date.

Signature of Parent / Guardian

/ /

Date

Written Medication Order and Authorization Form

BISHOP GRIMES Jr/Sr HIGH SCHOOL
6653 Kirkville Rd, East Syracuse, NY 13057
Health Office 463-8917 or 437-0356 Fax 437-0358

last name	first	grade	school year	date
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The school nurse will dispense **ALL** medication (prescription and over the counter-OTC) only with parental permission **AND** the licensed prescriber's written order. These medications must be brought to the health office in their original labeled containers. Complete the following section for all medications other than those noted below.

	name	dose/route	frequency/time	reason
1.	_____			
2.	_____			

parent/guardian signature

signature of MD, PA, or RNNP/stamp

The over the counter medications listed below will be provided by the school and dispensed by the nurse with parental permission **AND** the licensed prescribers signature.

Parent/guardian, check the box (es) of the medication(s) you permit your child to receive from the school nurse as needed.

Acetaminophen 325 mg, one to two tablets orally, every 4 hours as needed per package directions for headache pain or menstrual cramps.

Ibuprofen 200 mg, one to two tablets orally, every 4-6 hours as needed per package directions for headache, muscle aches, joint pain or menstrual cramps

parent/guardian signature

signature of MD, PA or RNNP/stamp

Self-carry authorization is only for asthma inhalers & EpiPen/AuviQ

- | | name | dose/route | frequency | reason |
|------------------------|-------|------------|-----------|--------|
| • Asthma inhaler order | _____ | | | |
| • Epi Pen/Auvi-Q order | _____ | | | |

My child has my permission and his/her licensed prescriber's authorization to properly use and carry his/her:

asthma inhaler epi-pen/Auvi-Q

Our licensed prescriber has instructed my child in the proper use, purpose and administration of this medication.

parent/guardian signature

signature of MD, PA or RNNP/stamp

BISHOP GRIMES JR./SR. HIGH SCHOOL
6635 Kirkville Road
East Syracuse, New York 13057
(315) 437-0356

AUTHORIZATION FOR EMERGENCY TREATMENT OF MINORS FORM

Name of Student: _____ Birth Date: _____

I/We being the parent(s) or legal guardian(s) of the above named student do hereby allow a qualified medical person to act in my/our behalf in authorizing medical, dental surgical care and hospitalization for the above named student in the event I cannot be reached.

<u>PARENT OR GUARDIAN</u>	<u>PARENT OR GUARDIAN</u>	<u>PARENT OR GUARDIAN</u>
_____ Signature	_____ Signature	_____ Signature
_____ Address	_____ Address	_____ Address
_____ State Zip	_____ State Zip	_____ State Zip
_____ Home Phone Work Phone	_____ Home Phone Work Phone	_____ Home Phone Work Phone

Please list below, special medical problems including allergies, etc.

If none(X) _____
OVER

BISHOP GRIMES JR./SR. HIGH SCHOOL
6635 Kirkville Road
East Syracuse, New York 13057
(315) 437-0356

AUTHORIZATION FOR EMERGENCY TREATMENT OF MINORS FORM

Name of Student: _____ Birth Date: _____

I/We being the parent(s) or legal guardian(s) of the above named student do hereby allow a qualified Medical person to act in my/or behalf in authorizing medical, dental surgical care and hospitalization for the above named student in the event I cannot be reached.

<u>PARENT OR GUARDIAN</u>	<u>PARENT OR GUARDIAN</u>	<u>PARENT OR GUARDIAN</u>
_____ Signature	_____ Signature	_____ Signature
_____ Address	_____ Address	_____ Address
_____ State Zip	_____ State Zip	_____ State Zip
_____ Home Phone Work Phone	_____ Home Phone Work Phone	_____ Home Phone Work Phone

Please list below, special medical problems including allergies, etc.

If none(X) _____
OVER

STUDENT _____

HOSPITALIZATION COVERAGE FOR THE ABOVE NAMED STUDENT

NAME OF INSURANCE CO.OR GOV'T PROGRAM IDENTIFICATION OR CONTRACT#

FAMILY PHYSICIAN(S)

NAME

PHONE#

NAME

PHONE#

This document shall be presented to a physician, dentist, or appropriate hospital representative at such time as emergency medical, dental, or surgical care or hospitalization may be required.

Name of Nearest Relative

Name of Nearest Relative

Address

Phone

Phone