

FRONTIER CENTRAL ATHLETIC DEPARTMENT



4432 BAY VIEW ROAD
HAMBURG, NY 14075-1399

Richard L. Gray, Director
Health, Physical Education, Recreation & Athletics
(716) 926-1704
FAX (716) 646-2188
Cell (716) 523-2870

Please answer ALL the following questions to help us provide the best possible care for your child in case of injury while participating in interscholastic activities at Frontier Central.

Name of Student: _____ Grade: _____

School: _____ Sport: _____ DOB: _____

Parents Name: _____

Home address: _____ Home Phone _____

Fathers Work Number _____ Cell number _____

Mothers Work Number _____ Cell number _____

Friend/Relative (Emergency Contact) Name _____

Home number: _____ Cell number: _____

Medical Provider: _____

Authorization:

Frontier Central School District contracts a certified *athletic trainer* for coverage of school athletics. This 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 responder 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.

*In case of emergency, if I cannot be reached, I authorize my child to receive emergency treatment, including treatment by a doctor other than our medical provider.

Parent Signature: _____

Date: _____

ALL FORMS MUST BE SIGNED BY PARENT/GUARDIAN NO SOONER THAN 30 DAYS BEFORE THE START OF SPORTS

Richard L. Gray

Frontier Falcons Sports Candidates Questionnaire

	YES		NO		YES		NO
Allergies _____	<input type="checkbox"/>		<input type="checkbox"/>	Headaches	<input type="checkbox"/>		<input type="checkbox"/>
Bee Sting Allergy	<input type="checkbox"/>		<input type="checkbox"/>	Head injury/concussion	<input type="checkbox"/>		<input type="checkbox"/>
Asthma	<input type="checkbox"/>		<input type="checkbox"/>	Heart problems/murmur/chest pain	<input type="checkbox"/>		<input type="checkbox"/>
Anemia	<input type="checkbox"/>		<input type="checkbox"/>	Nose bleeds frequent/severe	<input type="checkbox"/>		<input type="checkbox"/>
Arthritis	<input type="checkbox"/>		<input type="checkbox"/>	Bladder/kidney problem/injury	<input type="checkbox"/>		<input type="checkbox"/>
Ankle Injury	<input type="checkbox"/>		<input type="checkbox"/>	Back injury	<input type="checkbox"/>		<input type="checkbox"/>
Convulsions/Seizures	<input type="checkbox"/>		<input type="checkbox"/>	Fracture/dislocation bones/joints	<input type="checkbox"/>		<input type="checkbox"/>
Fainting Spells	<input type="checkbox"/>		<input type="checkbox"/>	Knee pain/injury	<input type="checkbox"/>		<input type="checkbox"/>
Diabetes	<input type="checkbox"/>		<input type="checkbox"/>	Neck injury	<input type="checkbox"/>		<input type="checkbox"/>
Ear problems/hearing loss	<input type="checkbox"/>		<input type="checkbox"/>	Nose fracture	<input type="checkbox"/>		<input type="checkbox"/>
Eye problems/vision loss	<input type="checkbox"/>		<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>		<input type="checkbox"/>
Injury to spleen	<input type="checkbox"/>		<input type="checkbox"/>	Stomach ulcer	<input type="checkbox"/>		<input type="checkbox"/>
Joint, muscle, ligament tear, sprain	<input type="checkbox"/>		<input type="checkbox"/>	Bleeding disorder	<input type="checkbox"/>		<input type="checkbox"/>
Wears contacts/glasses	<input type="checkbox"/>		<input type="checkbox"/>	Lung Problems	<input type="checkbox"/>		<input type="checkbox"/>
Elevated blood pressure	<input type="checkbox"/>		<input type="checkbox"/>	Other	<input type="checkbox"/>		<input type="checkbox"/>

Is there a family history of sudden death from heart disease at a young age?

Has your child had an illness/surgery within the past year since last physical requiring medical attention, which may hinder sports participation?

Has your child taken any medication in the past year?

Is your child taking any medication now?

Is your child under physicians care now?

Has your child had a surgical operation?

Do you have any worries about your child's health or other questions you would like to discuss?

If you have checked YES to any of the above questions, please explain in the space provided:

Parental Permission: I, the undersigned, clearly understand these questions are asked in order to decide if my child can safely participate on the athletic team named on the front part of this form. I understand that in order to best meet the needs of the athlete, relevant health information may need to be shared with the coach or athletic trainer. The answers are correct as of this date and he/she has my permission to participate.

Date: _____

Parent/Guardian Signatures: _____
