

Dear Parent or Guardian:

SSDS fully realizes that the physical development of the child is a vital and integral part of the field of education and is asking the cooperation of parents and guardians in our efforts to further the physical training program through extracurricular activities in the area of intramurals and interscholastic athletics.

Administration, teachers, coaches and the nurse want the assurance that each pupil taking part in the programs mentioned above is doing so WITH THE CONSENT OF HIS/HER PARENT OR GUARDIAN. Please complete the form below. NO STUDENT WILL BE ALLOWED TO PARTICIPATE UNTIL THIS FORM IS COMPLETED AND RETURNED TO THE NURSE, ALONG WITH HAVING A CURRENT SPORTS PHYSICAL FILED IN THE HEALTH OFFICE. **THIS IS IN ORDER TO COMPLY WITH NEW YORK STATE LAWS.**

Sincerely yours,
Frances R. Lopilato, RN
Coach Nicollee Inguagiato
Coach Kerry Dalton
Adele Spickler, Principal

I hereby give my son/daughter _____ permission to participate in the _____ program sponsored by SSDS. I recognize that the above activity involves the potential for injury, which is inherent in all sports. I acknowledge that even with the best coaching, the use of the most advanced protective equipment and the strictest observance of rules, injuries are still a possibility.

I further understand that all medical bills for an injury sustained in the above activity are to be submitted to the parent/guardian's insurance carrier.

Your signature below indicates that your child has your permission to participate.

Print Name: _____

Parent or Guardian's Signature: _____

Date: _____

SOLOMON SCHECHTER DAY SCHOOL OF NASSAU COUNTY
SOLOMON SCHECHTER HIGH SCHOOL OF LONG ISLAND
INTERSCHOLASTIC SPORTS HEALTH UPDATE FORM

Dear Parent or Guardian:
This form is to be completed before the start of each sports season, UNLESS the student has a sports physical already on file that is less than 30 days old. Please respond to the questions below and return this form to the Health Office. Any questions call 516-656-5500 ext. 1210.

CONTACT INFORMATION FOR AFTER SCHOOL HOURS

Student's Name _____

Date of Birth _____

Grade _____

Height _____

Weight _____

Address _____

Town/Zip Code _____

Home Telephone # _____

Mother's cell # _____

Father's cell # _____

In case of emergency, when parent not available, contact:

Name (Print) _____

Home Telephone # _____

Cell # _____

Name: _____

Date of Birth: _____

Sport: _____

Grade: _____

Since his/her last sports physical has this student:

- | | | |
|---|-------|------|
| 1. Had any injuries requiring medical attention? | Yes " | No " |
| 2. Had an illness lasting more than 5 days? | Yes " | No " |
| 3. Been taking any medicine(s) or been under a doctor's care? | Yes " | No " |
| 4. Had an operation or convulsion/head injury? | Yes " | No " |
| 5. Had any joint injuries (sprain, strains)? | Yes " | No " |
| 6. Had any fractures? | Yes " | No " |
| 7. Been treated in a hospital or emergency room? | Yes " | No " |
| 8. Developed any allergies or chronic disease? | Yes " | No " |
| 9. Had dizziness, faintness or fatigue after exercise/exertion? | Yes " | No " |
| 10. Wears glasses or contact lenses for sports? | Yes " | No " |

Explain any "Yes" answers:

Parent/Guardian's Signature: _____

Date: _____

EMERGENCY PROCEDURE

Student's Name: _____

In the event of a medical emergency, the procedure will be to call the parent, time permitting, before taking the student to a doctor or hospital. However, when neither parent can be reached, the following will permit prompt treatment.

I hereby give permission for the coach, intramural advisor, or designee to transport my child to a doctor or hospital for emergency treatment. I further give permission for the advisor, coach or designee to sign any consent(s) which may be necessary to allow hospital personnel and/or a licensed physician to examine my child and perform any emergency procedures, treatment or surgery which may be necessary and to consent to the administration of any drugs or medication necessary to such emergency care.

My child is allergic to the following drugs/medications/foods:

List any medical conditions &/or any medication(s) which your child has/takes:

I hereby agree to hold SSDS free and harmless from and indemnify SSDS from any liability which may arise as the result of such medical treatment.

Health Insurance Carrier: _____

Policy or ID Number: _____

Doctor's Name: _____

Phone # () _____

Parent's Signature: _____

Date: _____

SOLOMON SCHECHTER DAY SCHOOL OF NASSAU COUNTY

SOLOMON SCHECHTER HIGH SCHOOL OF LONG ISLAND

DEPARTMENT OF PHYSICAL EDUCATION & ATHLETICS

PERMISSION BOOKLET



**THIS BOOKLET MUST BE COMPLETED WITH THE
REQUIRED INFORMATION NO EARLIER THAN
TWO WEEKS PRIOR TO THE START OF THE
SEASON FOR EACH SPORT IN WHICH YOUR
CHILD WILL BE PARTICIPATING.**