C **(Submit Each Season)**

Schodack Central Schools Interscholastic Sports/Extracurricular Activity Health Eligibility Card

Name _____ Grade _____ Sex _____DOB _____

Address _____ Home Phone Number _____

Parent/Guardian Name _____ Cell Phone Number _____

Parent email address _____ Alternate Phone _____

Physician's Name & Phone# _____ Hospital Preference _____

Emergency Contact Name & Phone #'s _____

This certification is void if student has sustained an injury including a significant blow to the head or been absent from school for 5 consecutive days due to illness. A release must be obtained from the physician and recertification by the school nurse is necessary if any of the above occur. Students excused from physical education class are also restricted from participating in athletic events (practices and games). This certification applies to this sport season only. I have received and understand the SCSD concussion policy.

I understand the above and hereby give consent for my child (Name) _____ to participate in (Name Sport/Activity) _____ for the Schodack Central School District. I also hereby give my permission for school authorities to arrange for emergency medical treatment as needed.

Parent Signature/Date _____ Student Signature/Date_____

_____

School Nurse Certification Signature & Date

Health Comments
(Completed by School Nurse)

__ Glasses/Contacts __ Braces

__ Asthma __ Inhaler (see attached order and care plan)

__ Epi Pen for _____ allergy. (See attached order and care plan)

__ History of a concussion _____

__ History of fractures/injuries _____

__ Food Allergy (no emergency medication)

__ Other: