Martin Luther School

Small School. Smart Choice.

June 2021

Dear Parent/Guardian:

In accordance with Martin Luther School Policy and the New York State Department of Education Law, **a physical examination and a parent completed health history are mandated for students:**

- entering 7th, 9th, and 11th grades but is recommended annually.
- entering the school for the first time.
- who wish to participate in sports and required each year.

All exams are acceptable for 12 months from the date of examination with exception of any illness or injury. All forms must be signed, dated, and stamped by your child's health care provider to be accepted.

In addition, **ALL IMMUNIZATIONS** must be updated, signed, stamped and dated by your child' s health care provider to be accepted. ***Students who are not immunized are not permitted to come to school.***

****Please submit a copy of your child's Covid Immunization Card if he/she has been vaccinated****

All forms are available at the attendance office, on Blackbaud Resource page and available from coaches.

All required documentation must be handed in prior to the start of the sport season your child is trying out for or participating in. Students will not be permitted to try out or practice without paperwork. Any illness or injury sustained prior to the start of the athletic season or after completion of the physical examination form will require a heath care provider's note of release to participate. Students who participate in more than one season will be required to fill out a new health history and attestation form for each season.

As of July 2012, all parent/guardians must be aware of the concussion protocol Martin Luther must follow as per NYS law if your child is diagnosed with a concussion. Please review the student and parent information sheet and ***return signed acknowledgement.*** Parents/guardians are encouraged to obtain a baseline concussion test for their child.

In addition, if your child has need of medication daily or intermittently (for example - asthma pump or epi- pen), please have your health care provider fill out, sign, and stamp the Authorization of Administration of Medication and Independent Carry and Use forms.

I may be reached at aboyle@martinluthernyc.org or 718-894-4000 ext.127 with any further questions you may have.

Sincerely,

Ann Boyle
Athletic Director

Martin Luther School

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Interval Health History for Athletics

Student Name:	DOB: Age:
Grade (check): ☐6☐7 ☐8 ☐9 ☐10 ☐11 ☐12	Level (check): ☐Modified ☐JV ☐Varsity
Sport:	Limitations: ☐Yes ☐No
Date of last health exam:	Date form completed:

Health History To Be Completed By Parent/Guardian, Provide Details To Any Yes Answers On Page 3.
Any medications to be taken at practice and/or athletic event will require the proper paperwork, contact school with questions.

Has/Does your child:		
General Health Concerns	**Yes**	**No**
1. Ever been restricted by a doctor, physician assistant, or nurse practitioner from sports participation for any reason?		
2. Have an ongoing medical condition? ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Sickle Cell trait or disease ☐ Scoliosis ☐ Other		
3. Ever had surgery?		
4. Ever spent the night in a hospital?		
5. Been diagnosed with Mononucleosis within the last month?		
6. Have only one functioning kidney?		
7. Have a bleeding disorder?		
8. Have any problems with his/her hearing or wears hearing aid(s)?		
9. Have any problems with his/her vision or has vision in only one eye?		
10. Wear glasses or contacts?		
11. Has he/she ever fainted?		
12. Has he/she ever had Rheumatic fever?		
13. Is he/she currently taking any medications?		
Allergies	**Yes**	**No**
14. Have a life threatening allergy? Check any that apply: ☐ Food ☐ Insect Bite ☐ Latex ☐ Medicine ☐ Pollen ☐ Other		
15. Carry an epinephrine auto-injector?		
Breathing (Respiratory) Health	**Yes**	**No**
16. Ever complained of getting more tired or short of breath than his/her friends during exercise?		
17. Wheeze or cough frequently during or after exercise?		
18. Ever been told by their health care provider they have asthma?		
19. Use or carry an inhaler or nebulizer?		

Has/Does your child:		
Concussion/Head Injury History	**Yes**	**No**
20. Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told he/she had a concussion?		
21. Ever had a head injury or concussion?		
22. Ever had headaches with exercise?		
23. Ever had any unexplained seizures?		
24. Currently receive treatment for a seizure disorder or epilepsy?		
Devices/Accommodations	**Yes**	**No**
25. Use a brace, orthotic, or other device?		
26. Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)? If yes there may be need for another required form to be filled out.		
27. Wear protective eyewear, such as goggles or a face shield?		
Family History	**Yes**	**No**
28. Have any relative who's been diagnosed with a heart condition, such as a murmur, developed hypertrophic cardiomyopathy, Marfan Syndrome, Brugada Syndrome, right ventricular cardiomyopathy, long QT or short QT syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
Females Only	**Yes**	**No**
29. Begun having her period?		
30. Age periods began:		
31. Have regular periods?		
32. Date of last menstrual cycle?		
Males Only	**Yes**	**No**
33. Have only one testicle?		
34. Have groin pain or a bulge or hernia in the groin?		
Heart Health	**Yes**	**No**
35. Ever passed out during or after exercise?		
36. Ever complained of light headedness or dizziness during or after exercise?		
37. Ever complained of chest pain, tightness or pressure during or after exercise?		
38. Ever complained of fluttering in their chest, skipped beats, or their heart racing, or does he/she have a pacemaker?		
39. Ever had a test by their medical provider for his/her heart (e.g. EKG, echocardiogram stress test)?		
40. Ever been told they have a heart condition or problem by a physician? If so, check all that apply: ☐Heart infection ☐Heart Murmur ☐High Blood Pressure ☐Low Blood Pressure ☐High Cholesterol ☐Kawasaki Disease ☐Other:		
Injury History	**Yes**	**No**
41. Ever been diagnosed with a stress fracture?		
42. Ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling?		
43. Ever had an injury, pain, or swelling of joint that caused him/her to miss practice or a game?		
44. Have a bone, muscle, or joint injury that bothers him/her?		
45. Have joints become painful, swollen, warm, or red with use?		

Has/Does your child:		
Skin Health	**Yes**	**No**
46. Currently have any rashes, pressure sores, or other skin problems?		
47. Have had a herpes or MRSA skin infections?		
Stomach Health	**Yes**	**No**
48. Ever become ill while exercising in hot weather?		
49. Have a special diet or have to avoid certain foods?		
50. Have to worry about his/her weight?		
51. Have stomach problems?		
52. Ever had an eating disorder?		
COVID-19 Information		
Has your child ever tested positive for COVID-19?		
Was your child symptomatic?		
Did your child see a health care provider for their COVID-19 symptoms?		
Did your child have any cardiac symptoms (new fast or slow hear rate, chest tightness or pain, blood pressure changes, or health care provider diagnosed cardiac condition)? If yes, please provide additional information.		
Was your child hospitalized? If yes, provide dates : If yes, was your child diagnosed with Multisystem Inflammatory Syndrome (MISC) ? If yes, is your child under a health care provider's care for this?		

Please explain fully any question you answered yes to in the space below. (Please print clearly and provide dates if known.)

_____

_____

_____

_____

I hereby state that my child has had no serious illness or history of serious illness other than noted above, which has come to my knowledge through either physician or practitioner who has treated him/her in the past. To the best of my knowledge he/she does not have a serious condition which might prevent his/her safe participation in school athletic activities.

_____ _____

SIGNATURE OF PARENT/GUARDIAN DATE

COUGAR ATHLETICS - PERMISSION -PARENTAL/GUARDIAN AUTHORIZATION PARTICIPATION

We _____ the parent(s)/guardian(s) of _____ herby

give my/our permission for him/her to participate in _____ (name of sport and level).

We herby authorize the school representatives to act on my/our behalf with respect to any required medical treatment decisions and consents, until such time we/I are able to provide these items. Notice is herby given to any qualified medical personnel that this authorization is currently in effect, and such personnel are directed to act upon such authorization without delay. I/we understand that my son/daughter is responsible for all equipment issued, and if any equipment issued is not returned, I/we shall reimburse the school for its replacement value.

_____ _____

DATE PARENT/GUARDIAN SIGNATURE(S)

_____ _____

HOME ADDRESS HOME & BUSINESS TELEPHONE NUMBERS

_____ _____ _____

SIGNATURE OF ATHLETE DATE OF BIRTH GRADE

Revised12.20

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly

NYC ID (OSIS)

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Last Name | First Name | Middle Name | Sex ☐ Female ☐ Male | Date of Birth *(Month/Day/Year)* ___/___/___

Child's Address | Hispanic/Latino? ☐ Yes ☐ No | Race *(Check ALL that apply)* ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other

City/Borough | State | Zip Code | School/Center/Camp Name | District ___ Number ___ | Phone Numbers: Home / Cell / Work

Health Insurance (including Medicaid)? ☐ Yes ☐ No | ☐ Parent/Guardian ☐ Foster Parent | Last Name | First Name | Email

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* _____

☐ Foods *(list)* _____

☐ Other *(list)* _____

Attach MAF if in-school medications needed

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma *(check severity and attach MAF):* ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Quick Relief Medication ☐ Inhaled Corticosteroid ☐ Oral Steroid ☐ Other Controller ☐ None

Asthma Control Status ☐ Well-controlled ☐ Poorly Controlled or Not Controlled

☐ Anaphylaxis ☐ Seizure disorder

☐ Behavioral/mental health disorder ☐ Speech, hearing, or visual impairment

☐ Congenital or acquired heart disorder ☐ Tuberculosis *(latent infection or disease)*

☐ Developmental/learning problem ☐ Hospitalization

☐ Diabetes *(attach MAF)* ☐ Surgery

☐ Orthopedic injury/disability ☐ Other (specify) _____

Explain all checked items above. ☐ ***Addendum attached.***

Medications *(attach MAF if in-school medication needed)*

☐ None ☐ Yes *(list below)*

PHYSICAL EXAM Date of Exam: ___/___/___

Height _____ cm (___ ___ %ile)

Weight _____ kg (___ ___ %ile)

BMI _____ kg/m² (___ ___ %ile)

Head Circumference *(age ≤2 yrs)* _____ cm (___ ___ %ile)

Blood Pressure *(age ≥3 yrs)* _____ / _____

General Appearance:

☐ Physical Exam WNL

	NI	Abnl
Psychosocial Development	☐	☐
Language	☐	☐
Behavioral	☐	☐
HEENT	☐	☐
Dental	☐	☐
Neck	☐	☐
Lymph nodes	☐	☐
Lungs	☐	☐
Cardiovascular	☐	☐
Abdomen	☐	☐
Genitourinary	☐	☐
Extremities	☐	☐
Skin	☐	☐
Neurological	☐	☐
Back/spine	☐	☐

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)*

Validated Screening Tool Used? ☐ Yes ☐ No — Date Screened ___/___/___

Screening Results: ☐ WNL

☐ Delay or Concern Suspected/Confirmed (specify area(s) below):

☐ Cognitive/Problem Solving ☐ Adaptive/Self-Help

☐ Communication/Language ☐ Gross Motor/Fine Motor

☐ Social-Emotional or Personal-Social ☐ Other Area of Concern: _____

Describe Suspected Delay or Concern:

Child Receives EI/CPSE/CSE services ☐ Yes ☐ No

Nutrition

< 1 year ☐ Breastfed ☐ Formula ☐ Both

≥ 1 year ☐ Well-balanced ☐ Needs guidance ☐ Counseled ☐ Referred

Dietary Restrictions ☐ None ☐ Yes *(list below)*

SCREENING TESTS	Date Done	Results
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	___/___/___	_____ µg/dL
	___/___/___	_____ µg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	___/___/___	☐ At risk *(do BLL)* ☐ Not at risk
Child Care Only		
Hemoglobin or Hematocrit	___/___/___	_____ g/dL _____ %

Hearing

	Date Done	Results
< 4 years: gross hearing	___/___/___	☐ NI ☐ Abnl ☐ Referred
OAE	___/___/___	☐ NI ☐ Abnl ☐ Referred
≥ 4 yrs: pure tone audiometry	___/___/___	☐ NI ☐ Abnl ☐ Referred

Vision

	Date Done	Results
<3 years: Vision appears:	___/___/___	☐ NI ☐ Abnl
Acuity (required for new entrants and children age 3-7 years)	___/___/___	Right ___/___ Left ___/___ ☐ Unable to test
Screened with Glasses?		☐ Yes ☐ No
Strabismus?		☐ Yes ☐ No

Dental

Visible Tooth Decay	☐ Yes ☐ No
Urgent need for dental referral *(pain, swelling, infection)*	☐ Yes ☐ No
Dental Visit within the past 12 months	☐ Yes ☐ No

CIR Number | Physician Confirmed History of Varicella Infection ☐

Report only positive immunity:

IMMUNIZATIONS – DATES

DTP/DTaP/DT	___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___	Tdap	___/___/___	___/___/___	___/___/___
Td	___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___	MMR	___/___/___	___/___/___	___/___/___
Polio	___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___	Varicella	___/___/___	___/___/___	___/___/___
Hep B	___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___	Mening ACWY	___/___/___	___/___/___	___/___/___
Hib	___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___	Hep A	___/___/___	___/___/___	___/___/___
PCV	___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___	Rotavirus	___/___/___	___/___/___	___/___/___
Influenza	___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___	Mening B	___/___/___	___/___/___	___/___/___
HPV	___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___	Other _____	___/___/___	_____ ___/___/___	

IgG Titers	Date
Hepatitis B	___/___/___
Measles	___/___/___
Mumps	___/___/___
Rubella	___/___/___
Varicella	___/___/___
Polio 1	___/___/___
Polio 2	___/___/___
Polio 3	___/___/___

ASSESSMENT ☐ **Well Child** (Z00.129) ☐ **Diagnoses/Problems** *(list)* — **ICD-10 Code**

RECOMMENDATIONS ☐ Full physical activity

☐ Restrictions *(specify)* _____

Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: ___/___/___

Referral(s): ☐ None ☐ Early Intervention ☐ IEP ☐ Dental ☐ Vision

☐ Other _____

Health Care Practitioner Signature | Date Form Completed ___/___/___

DOHMH ONLY PRACTITIONER I.D.

Health Care Practitioner Name and Degree *(print)* | Practitioner License No. and State

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments:

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Date Reviewed: ___/___/___ **I.D. NUMBER**

REVIEWER:

Telephone | Fax | Email

FORM ID#

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION & SPORTS

To be completed by student's health care provider or school medical provider

This page must be submitted to coach or athletic director before PSAL participation.

Last Name	First Name	OSIS#	Grade

School/Campus/ATSDBN

❑ **CLEARED FOR ALL SPORTS WITHOUT RESTRICTION**

❑ **NOT CLEARED** **Duration:** _____

❑ **NOT CLEARED PENDING FURTHER EVALUATION** _____

❑ **CLEARED FOR ALL SPORTS WITHOUT RESTRICTION WITH RECOMMENDATIONS FOR FURTHER EVALUATION OR TREATMENT FOR:** _____

_____

❑ **CLEARED WITH RESTRICTIONS/ADAPTATIONS/ACCOMMODATIONS** **Duration:** _____

❑ **NO CONTACT SPORTS:** includes basketball, competitive cheerleading, diving, field hockey, football (tackle), gymnastics, ice hockey, lacrosse, rugby, soccer, stunt, wrestling

❑ **NO LIMITED CONTACT SPORTS:** includes baseball, cross-country skiing, fencing, flag football, handball, high jump, ice skating, pole vault, skiing, softball, volleyball

❑ **NO NON-CONTACT SPORTS:** includes archery, badminton, bowling, cricket, discus, double dutch, golf, javelin, race walking, rifle, shot-put, swimming, table tennis, tennis, track & field

❑ **OTHER RESTRICTIONS** _____

_____

ACCOMMODATIONS/PROTECTIVE EQUIPMENT

❑ None ❑ Athletic Cup ❑ Sports/Safety Goggles ❑ Medical/Prosthetic Device ❑ Pacemaker ❑ Insulin Pump/Insulin Sensor

❑ Brace/Orthotic ❑ Hearing Aides ❑ Protective Ear Gear ❑ Other _____

❑ **PERTINENT MEDICAL HISTORY** _____

❑ **ALLERGIES** _____ ❑ None

MEDICATIONS

❑ Has prescribed pre-exercise medication _____

❑ Has prescribed PRN medication _____

❑ Student is Self-Carry/Self-Administer, **unless in an emergency or student is incapable of self-administration**

Explanation _____

_____

❑ **OTHER RECOMMENDATIONS** _____

_____

_____

I have examined the above named student and completed the pre-participation physical examination, INCLUDING A REVIEW OF ANY MEDICAL HISTORY RELATED TO COVID-19. The athlete may/may not participate in the sport(s) as outlined above. A copy of the physical exam will be provided to the school medical room staff and can be made available to the school administration at the request of the parents. This form may be rescinded: by a medical provider if there are any changes in the student's health that could affect his/her safe participation in sports, and/or until the potential consequences of the health issue are explained to both the student and his/her parents, and the health issue has been resolved. All information and recommendations contained herein are valid through the last day of the month for 12 months from the date below.

Name of medical provider (print/type)	Title	License/NPI

Address			Medical Provider's Stamp
Phone	**Fax**	**Email**	
Signature of medical provider		**Date**	

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PROVIDER ATTESTATION AND PARENT PERMISSIONS FOR INDEPENDENT MEDICATION CARRY AND USE

Directions for the Health Care Provider: This form may be used as an addendum to a medication order which does not contain the required diagnosis and attestation for a student to independently carry and use their medication as required by NYS law. A **provider order** and **parent/guardian permission** are needed in order for a student to carry and use medications that require rapid administration to prevent negative health outcomes. These medications should be identified by checking the appropriate boxes below.

Student Name: _____ **DOB:** _____ **Grade:** _____

Health Care Provider Permission for Independent Use and Carry

I attest that this student has demonstrated to me that he or she can self-administer the medication(s) listed below safely and effectively, and may carry and use this medication (with a delivery device if needed) independently during school and school sponsored activities. Staff intervention and support is needed only during an emergency. This order applies to the medications checked below:
This student is diagnosed with:

- ☐ Allergy and requires Epinephrine Auto-injector
- ☐ Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication
- ☐ Diabetes and requires Insulin/Glucagon/Diabetes Supplies
- ☐ _____ which requires rapid administration of _____
  (State Diagnosis) (Medication Name)

Doctor's Name (Please Print): _____

Signature: _____ Date: _____

Please Stamp

Parent/Guardian Permission for Independent Use and Carry

I agree that my child can use their medication effectively and may carry and use this medication independently during school and school sponsored activities. Staff intervention and support is needed only during an emergency.

Parent/Guardian's Name (Please Print): _____

Signature: _____ Date: _____

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PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

Name: _____ DOB: _____ Grade: _____

A. **To be completed by the parent or guardian:**
I request that my child receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy.

Parent/Guardian's Name (Please Print): _____

Signature (Parent or Guardian): _____ Date: _____

Telephone: Cell : _____ Home: _____ Work: _____

B. **To be completed by physician:**
I request that my patient, as listed below, receive the following medication:

Name of Student: _____ DOB: _____

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN

Duration of Treatment: _____

Possible Side Effects and Adverse Reactions (if any): _____

Physician's Name (Please Print): _____

Physician's Signature: _____ Date: _____

Address: _____ Phone: _____

Please Stamp

Please return this form with the medication to the Attendance Office

6/26/2020

2021-22 School Year
New York State Immunization Requirements for School Entrance/Attendance[1]

NOTES:
Children in a prekindergarten setting should be age-appropriately immunized. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. See footnotes for specific information for each vaccine. Children who are enrolling in grade-less classes should meet the immunization requirements of the grades for which they are age equivalent.

Dose requirements MUST be read with the footnotes of this schedule

<table>
<tr><th>Vaccines</th><th>Prekindergarten (Day Care, Head Start, Nursery or Pre-k)</th><th>Kindergarten and Grades 1, 2, 3, 4 and 5</th><th>Grades 6, 7, 8, 9, 10 and 11</th><th>Grade 12</th></tr>
<tr><td>Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td)[2]</td><td>4 doses</td><td>5 doses
or 4 doses
if the 4th dose was received at 4 years or older or
3 doses
if 7 years or older and the series was started at 1 year or older</td><td colspan="2">3 doses</td></tr>
<tr><td>Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap)[3]</td><td colspan="2">Not applicable</td><td colspan="2">1 dose</td></tr>
<tr><td>Polio vaccine (IPV/OPV)[4]</td><td>3 doses</td><td colspan="3">4 doses
or 3 doses
if the 3rd dose was received at 4 years or older</td></tr>
<tr><td>Measles, Mumps and Rubella vaccine (MMR)[5]</td><td>1 dose</td><td colspan="3">2 doses</td></tr>
<tr><td>Hepatitis B vaccine[6]</td><td>3 doses</td><td colspan="3">3 doses
or 2 doses of adult hepatitis B vaccine (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years</td></tr>
<tr><td>Varicella (Chickenpox) vaccine[7]</td><td>1 dose</td><td colspan="3">2 doses</td></tr>
<tr><td>Meningococcal conjugate vaccine (MenACWY)[8]</td><td colspan="2">Not applicable</td><td>Grades 7, 8, 9, 10 and 11:
1 dose</td><td>2 doses
or 1 dose
if the dose was received at 16 years or older</td></tr>
<tr><td>Haemophilus influenzae type b conjugate vaccine (Hib)[9]</td><td>1 to 4 doses</td><td colspan="3">Not applicable</td></tr>
<tr><td>Pneumococcal Conjugate vaccine (PCV)[10]</td><td>1 to 4 doses</td><td colspan="3">Not applicable</td></tr>
</table>

1. Demonstrated serologic evidence of measles, mumps or rubella antibodies or laboratory confirmation of these diseases is acceptable proof of immunity to these diseases. Serologic tests for polio are acceptable proof of immunity only if the test was performed before September 1, 2019 and all three serotypes were positive. A positive blood test for hepatitis B surface antibody is acceptable proof of immunity to hepatitis B. Demonstrated serologic evidence of varicella antibodies, laboratory confirmation of varicella disease or diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
   b. If the fourth dose of DTaP was administered at 4 years or older, and at least 6 months after dose 3, the fifth (booster) dose of DTaP vaccine is not required.
   c. For children born before 1/1/2005, only immunity to diphtheria is required and doses of DT and Td can meet this requirement.
   d. Children 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td or Tdap vaccine. If the first dose was received before their first birthday, then 4 doses are required, as long as the final dose was received at 4 years or older. If the first dose was received on or after the first birthday, then 3 doses are required, as long as the final dose was received at 4 years or older.

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) adolescent booster vaccine. (Minimum age for grades 6 and 7: 10 years; minimum age for grades 8 through 12: 7 years)
   a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap.
   b. In addition to the grade 6 through 12 requirement, Tdap may also be given as part of the catch-up series for students 7 years of age and older who are not fully immunized with the childhood DTaP series, as described above. In school year 2021-2022, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grades 6 and 7; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grades 8 through 12.
   c. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years old.

4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
   b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.
   c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.
   d. For children with a record of OPV, only trivalent OPV (tOPV) counts toward NYS school polio vaccine requirements. Doses of OPV given before April 1, 2016 should be counted unless specifically noted as monovalent, bivalent or as given during a poliovirus immunization campaign. Doses of OPV given on or after April 1, 2016 should not be counted.

5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)
   a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
   b. Measles: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
   c. Mumps: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
   d. Rubella: At least one dose is required for all grades (prekindergarten through 12).

6. Hepatitis B vaccine
   a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks (when 4 doses are given, substitute "dose 4" for "dose 3" in these calculations).
   b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.

7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)
   a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
   b. For children younger than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons 13 years and older, the minimum interval between doses is 4 weeks.

8. Meningococcal conjugate ACWY vaccine (MenACWY). (Minimum age for grades 7 and 8: 10 years; minimum age for grades 9 through 12: 6 weeks).
   a. One dose of meningococcal conjugate vaccine (Menactra, Menveo or MenQuadfi) is required for students entering grades 7, 8, 9, 10 and 11.
   b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.
   c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.

9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
   b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.
   c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.
   d. If dose 1 was received at 15 months or older, only 1 dose is required.
   e. Hib vaccine is not required for children 5 years or older.

10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
   b. Unvaccinated children ages 7 through 11 months are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.
   c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.
   d. If one dose of vaccine was received at 24 months or older, no further doses are required.
   e. PCV is not required for children 5 years or older.
   f. For further information, refer to the PCV chart available in the School Survey Instruction Booklet at: www.health.ny.gov/prevention/immunization/schools

For further information, contact:

New York State Department of Health
Bureau of Immunization
Room 649, Corning Tower ESP
Albany, NY 12237
(518) 473-4437

New York City Department of Health and Mental Hygiene
Program Support Unit, Bureau of Immunization,
42-09 28th Street, 5th floor
Long Island City, NY 11101
(347) 396-2433

Martin Luther School

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Parental Permission

I have received, read, and understand the Concussion student and parent information document. I understand the signs and symptoms of a concussion and give permission for the First Responder to conduct a sideline assessment to determine whether further medical care is necessary if there is suspicion that my child has withstood a head injury during school or a school sponsored event. I understand that only school personnel can perform my child's return to play protocol.

Student Name: _____ Grade: _____

Parent/Guardian Name and Signature: _____ Date: _____

Martin Luther School Concussion Policy

Concussion Management

Martin Luther School recognizes that concussions and head injuries are commonly reported injures in children and adolescents who participate in sports and recreational activity and can have serious consequences if not managed carefully. Therefore, Martin Luther school has adopted the following policies to support the proper evaluation and management of head injuries.

Concussion is a mild traumatic brain injury. Concussion occurs when normal brain functioning is disrupted by a blow or jolt to the head. Recovery from concussion will vary. Avoiding re-injury and over-exertion until fully recovered are the cornerstones of proper concussion management.

While staff will exercise reasonable care to protect students, head injuries may still occur. Physical education teachers, coaches and other appropriate staff receive annual training to recognize the signs, symptoms and behaviors consistent with a concussion. Information is also available on the school's website and is provided as part of permission for participating in interscholastic sports and addressed in physical education classes.

Martin Luther School's concussion coordinator is Ms. Ann Boyle, athletic director and can be reached at aboyle@martinluthernyc.org or at 718-894-4000 ext.127. Ms. Boyle will assist parents/guardians and students in the process of handling a concussion within the context of school and athletics.

Any student exhibiting signs, symptoms or behaviors while participating in a school sponsored class, extracurricular activity, or interscholastic athletic activity shall be removed from the game or activity and be evaluated as soon as possible by an appropriate health care professional. The athletic director, coach, teacher or other supervising adult will notify the student's parents or guardians and recommend appropriate monitoring and medical evaluation.

If a student sustains a concussion at a time other than when engaged in a school-sponsored activity, the school expects the parent/guardian to report the condition to the athletic director so that the school can support the appropriate management of the condition.

The student shall not return to athletic activity until he/she is symptom free for at least 24 hours and has been evaluated by and provides written authorization from an appropriate health care professional. The school's athletic director will make the final decision on return to an activity, including physical education class and after-school sports. Any student who continues to have signs or symptoms upon return to activity must be removed from play and reevaluated by their health care provider.

Any parental consent forms required for participation in athletics will include information on head injuries. Parents/guardians are encouraged to obtain a baseline concussion test for their child.

The athletic director will develop regulations and protocols to guide the return to activity. The school shall periodically review this policy to ensure its continued compliance with state regulations and guidance.

http://www.nysphsaa.org/portals/0/pdf/safety/StudentParentConcussionInformation.pdf

https://www.cdc.gov/headsup/highschoolsports/index.html

Concussions: The Invisible Injury

Student and Parent Information Sheet

CONCUSSION DEFINITION

A concussion is a reaction by the brain to a jolt or force that can be transmitted to the head by an impact or blow occurring anywhere on the body. Essentially a concussion results from the brain moving back and forth or twisting rapidly inside the skull.

FACTS ABOUT CONCUSSIONS ACCORDING TO THE CENTER FOR DISEASE CONTROL (CDC)

- An estimated 4 million people under age 19 sustain a head injury annually. Of these approximately 52,000 die and 275,000 are hospitalized.
- An estimated 300,000 sports and recreation related concussions occur each year.
- Students who have had at least one concussion are at increased risk for another concussion.

In New York State in 2009, approximately 50,500 children under the age of 19 visited the emergency room for a traumatic brain injury and of those approximately 3,000 were hospitalized.

REQUIREMENTS OF SCHOOL DISTRICTS

Education:

- Each school coach, physical education teacher, nurse, and athletic trainer will have to complete an approved course on concussion management on a biennial basis, starting with the 2012-2013 school year.
  - School coaches and physical education teachers must complete the CDC course. (www.cdc.gov/concussion/HeadsUp/online_training.html)
  - School nurses and certified athletic trainers must complete the concussion course. (http://preventingconcussions.org)

Information:

- Provide concussion management information and sign off with any parental permission form.
- The concussion management and awareness information or the State Education Department's web site must be made available on the school web site, if one exists.

Removal from athletics:

- Require the immediate removal from athletic activities of any pupil that has or is believed to have sustained a mild traumatic brain injury.
- No pupils will be allowed to resume athletic activity until they have been symptom free for 24 hours and have been evaluated by and received written and signed authorization from a licensed physician. For interscholastic athletics, clearance must come from the school medical director.
  - Such authorization must be kept in the pupil's permanent heath record.
  - Schools shall follow directives issued by the pupil's treating physician.

SYMPTOMS

Symptoms of a concussion are the result of a temporary change in the brain's function. In most cases, the symptoms of a concussion generally resolve over a short period of time; however, in some cases, symptoms will last for weeks or longer. Children and adolescents are more susceptible to concussions and take longer than adults to recover.

It is imperative that any student who is suspected of having a concussion is removed from athletic activity (e.g. recess, PE class, sports) and remains out of such activities until evaluated and cleared to return to activity by a physician.

Symptoms include, but are not limited to:

- Decreased or absent memory of events prior to or immediately after the injury, or difficulty retaining new information
- Confusion or appears dazed
- Headache or head pressure
- Loss of consciousness
- Balance difficulties, dizziness, or clumsy movements
- Double or blurry vision
- Sensitivity to light and/or sound
- Nausea, vomiting and/or loss of appetite
- Irritability, sadness or other changes in personality
- Feeling sluggish, foggy or light-headed
- Concentration or focusing problems
- Drowsiness
- Fatigue and/or sleep issues – sleeping more or less than usual

Students who develop any of the following signs, or if signs and symptoms worsen, should be seen and evaluated immediately at the nearest hospital emergency room.

- Headaches that worsen
- Seizures
- Looks drowsy and/or cannot be awakened
- Repeated vomiting
- Slurred speech
- Unable to recognize people or places
- Weakness or numbing in arms or legs, facial drooping
- Unsteady gait
- Change in pupil size in one eye
- Significant irritability
- Any loss of consciousness
- Suspicion for skull fracture: blood draining from ear or clear fluid from the nose

STATE EDUCATION DEPARTMENT'S GUIDANCE FOR CONCUSSION MANAGEMENT

Schools are advised to develop a written concussion management policy. A sample policy is available on the NYSPHSAA web site at www.nysphsaa.org. The policy should include:

- A commitment to reduce the risk of head injuries.
- A procedure and treatment plan developed by the district medical director.
- A procedure to ensure proper education for school nurses, certified athletic trainers, physical education teachers, and coaches.
- A procedure for a coordinated communication plan among appropriate staff.
- A procedure for periodic review of the concussion management program.

RETURN TO LEARN and RETURN TO PLAY PROTOCOLS

Cognitive Rest: Activities students should avoid include, but are not limited to, the following:

- Computers and video games
- Television viewing
- Texting
- Reading or writing
- Studying or homework
- Taking a test or completing significant projects
- Loud music
- Bright lights

Students may only be able to attend school for short periods of time. Accommodations may have to be made for missed tests and assignments.

Physical Rest: Activities students should avoid include, but are not limited to, the following:

- Contact and collision
- High speed, intense exercise and/or sports
- High risk for re-injury or impacts
- Any activity that results in an increased heart rate or increased head pressure

Return to Play Protocol once symptom free for 24 hours and cleared by School Medical Director:

Day 1: Low impact, non strenuous, light aerobic activity.

Day 2: Higher impact, higher exertion, moderate aerobic activity. No resistance training.

Day 3: Sport specific non-contact activity. Low resistance weight training with a spotter.

Day 4: Sport specific activity, non-contact drills. Higher resistance weight training with a spotter.

Day 5: Full contact training drills and intense aerobic activity.

Day 6: Return to full activities with clearance from School Medical Director.

Any return of symptoms during the return to play protocol, the student will return to previous day's activities until symptom free.

CONCUSSION MANAGEMENT TEAM

Schools may, at their discretion, form a concussion management team to implement and monitor the concussion management policy and program. The team could include, but is not limited to, the following:

- Students
- Parents/Guardians
- School Administrators
- Medical Director
- Private Medical Provider
- School Nurse
- Director of Physical Education and/or Athletic Director
- Certified Athletic Trainer
- Physical Education Teacher and/or Coaches
- Classroom Teachers

OTHER RESOURCES

- New York State Education Department

http://www.p12.nysed.gov/sss/schoolhealth/schoolhealthservices

- New York State Department of Health

http://www.health.ny.gov/prevention/injury_prevention/concussion/htm

- New York State Public High School Athletic Association

www.nysphsaa.org/safety/

- Center for Disease Control and Prevention

http://cdc.gov/TraumaticBrainInjury

- National Federation of High Schools

www.nfhslearn.com – The FREE Concussion Management course does not meet education requirement.

- Child Health Plus

http://www.health.ny.gov/health_care/managed_care/consumer_guide/about_child_health_plus.htm

- Local Department of Social Services – New York State Department of Health

http://www.health.ny.gov/health_care/medicaid/ldss/htm

- Brain Injury Association of New York State

http://www.bianys.org

- Nationwide Children's Hospital – Concussions in the Classroom

http://www.nationwidechildrens.org/concussions-in-the-classroom

- Upstate University Hospital – Concussions in the Classroom

http://www.upstate.edu/pmr/healthcare/programs/concussion/classroom.php

- ESPN Video – Life Changed by Concussion

http://espn.go.com/video/clip?id=7525526&categoryid=5595394

- SportsConcussions.org

http://www.sportsconcussions.org/ibaseline/

- American Association of Neurological Surgeons

http://www.aans.org/Patient%20Information/Conditions%20and%20Treatment/Concussion.aspx

- Consensus Statement on Concussion in Sport – Zurich

http://sportconcussions.com/html/Zurich%20Statement.pdf

Concussion
INFORMATION SHEET

CDC HEADS UP
SAFE BRAIN. STRONGER FUTURE.

This sheet has information to help protect your children or teens from concussion or other serious brain injury. Use this information at your children's or teens' games and practices to learn how to spot a concussion and what to do if a concussion occurs.

What Is a Concussion?

A concussion is a type of traumatic brain injury—or TBI—caused by a bump, blow, or jolt to the head or by a hit to the body that causes the head and brain to move quickly back and forth. This fast movement can cause the brain to bounce around or twist in the skull, creating chemical changes in the brain and sometimes stretching and damaging the brain cells.

How Can I Help Keep My Children or Teens Safe?

Sports are a great way for children and teens to stay healthy and can help them do well in school. To help lower your children's or teens' chances of getting a concussion or other serious brain injury, you should:

- Help create a culture of safety for the team.
  - Work with their coach to teach ways to lower the chances of getting a concussion.
  - Talk with your children or teens about concussion and ask if they have concerns about reporting a concussion. Talk with them about their concerns; emphasize the importance of reporting concussions and taking time to recover from one.
  - Ensure that they follow their coach's rules for safety and the rules of the sport.
  - Tell your children or teens that you expect them to practice good sportsmanship at all times.
- When appropriate for the sport or activity, teach your children or teens that they must wear a helmet to lower the chances of the most serious types of brain or head injury. However, there is no "concussion-proof" helmet. So, even with a helmet, it is important for children and teens to avoid hits to the head.

Plan ahead. What do you want your child or teen to know about concussion?

How Can I Spot a Possible Concussion?

Children and teens who show or report one or more of the signs and symptoms listed below—or simply say they just "don't feel right" after a bump, blow, or jolt to the head or body—may have a concussion or other serious brain injury.

Signs Observed by Parents or Coaches

- Appears dazed or stunned
- Forgets an instruction, is confused about an assignment or position, or is unsure of the game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes
- Can't recall events *prior to* or *after* a hit or fall

Symptoms Reported by Children and Teens

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness, or double or blurry vision
- Bothered by light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Confusion, or concentration or memory problems
- Just not "feeling right," or "feeling down"

Talk with your children and teens about concussion. Tell them to report their concussion symptoms to you and their coach right away. Some children and teens think concussions aren't serious, or worry that if they report a concussion they will lose their position on the team or look weak. Be sure to remind them that *it's better to miss one game than the whole season.*

CDC

cdc.gov/HEADSUP

CONCUSSIONS AFFECT EACH CHILD AND TEEN DIFFERENTLY.

While most children and teens with a concussion feel better within a couple of weeks, some will have symptoms for months or longer. Talk with your children's or teens' healthcare provider if their concussion symptoms do not go away, or if they get worse after they return to their regular activities.

What Are Some More Serious Danger Signs to Look Out For?

In rare cases, a dangerous collection of blood (hematoma) may form on the brain after a bump, blow, or jolt to the head or body and can squeeze the brain against the skull. Call 9-1-1 or take your child or teen to the emergency department right away if, after a bump, blow, or jolt to the head or body, he or she has one or more of these danger signs:

- One pupil larger than the other
- Drowsiness or inability to wake up
- A headache that gets worse and does not go away
- Slurred speech, weakness, numbness, or decreased coordination
- Repeated vomiting or nausea, convulsions or seizures (shaking or twitching)
- Unusual behavior, increased confusion, restlessness, or agitation
- Loss of consciousness (passed out/knocked out). Even a brief loss of consciousness should be taken seriously

Children and teens who continue to play while having concussion symptoms, or who return to play too soon—while the brain is still healing—have a greater chance of getting another concussion. A repeat concussion that occurs while the brain is still healing from the first injury can be very serious, and can affect a child or teen for a lifetime. It can even be fatal.

What Should I Do If My Child or Teen Has a Possible Concussion?

As a parent, if you think your child or teen may have a concussion, you should:

1. Remove your child or teen from play.
2. Keep your child or teen out of play the day of the injury. Your child or teen should be seen by a healthcare provider and only return to play with permission from a healthcare provider who is experienced in evaluating for concussion.
3. Ask your child's or teen's healthcare provider for written instructions on helping your child or teen return to school. You can give the instructions to your child's or teen's school nurse and teacher(s) and return-to-play instructions to the coach and/or athletic trainer.

Do not try to judge the severity of the injury yourself. Only a healthcare provider should assess a child or teen for a possible concussion. Concussion signs and symptoms often show up soon after the injury. But you may not know how serious the concussion is at first, and some symptoms may not show up for hours or days.

The brain needs time to heal after a concussion. A child's or teen's return to school and sports should be a gradual process that is carefully managed and monitored by a healthcare provider.

To learn more, go to cdc.gov/HEADSUP

CDC HEADS UP

Discuss the risks of concussion and other serious brain injuries with your child or teen, and have each person sign below.

Detach the section below, and keep this information sheet to use at your children's or teens' games and practices to help protect them from concussion or other serious brain injuries.

○ I learned about concussion and talked with my parent or coach about what to do if I have a concussion or other serious brain injury.

Athlete's Name Printed:_____ Date:_____

Athlete's Signature:_____

○ I have read this fact sheet for parents on concussion with my child or teen, and talked about what to do if they have a concussion or other serious brain injury.

Parent or Legal Guardian's Name Printed:_____ Date:_____

Parent or Legal Guardian's Signature:_____

Revised January 2019

Martin Luther School

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Athletics Parental Consent Form

YEAR_____

_____ _____

Student's Name Date of Birth

_____ _____

Sport Grade

A Parent/Guardian must read and initial next to the following statements.

1. I, the parent/guardian of the student named above, hereby give permission for my child to try out for the team indicated, and participate in all of the team's activities, as directed by the school/coach. I understand that my child's participation in this activity is purely voluntary. However, if selected, I understand that my child be required to attend regularly scheduled practices and competitions.	**Initial** _____
2. I understand that my child will meet all MLS practice and participation requirements.	**Initial** _____
3. I understand that my child is responsible for her/his behavior at all time and agree not to hold the school or any of its employees responsible for any expenses or damages incurred as a result of my child's behavior. I also understand that any violation of the school's code of discipline may result in exclusion from the team.	**Initial** _____
4. I understand that it is necessary for my child to have an approved medical certificate for school competition on file in the school before trying out, practicing or competing in interscholastic athletic activities. I agree to inform the school of any change in my child's medical or physical condition which develops or is discovered at any time after the date this document is signed.	**Initial** _____
5. I understand that with the participation in sports comes the risk of injury, particularly with contact sports. Such injuries may include, but not be limited to, concussions, COVID-19, and injury to bones, neck, spine, or internal organs. I understand the risks involved and expressly agree to accept all the risks existing in the sport in which my child will be participating.	**Initial** _____
6. I have received and read the "Concussion Information Sheet" and am aware of COVID-19 information. I agree to thoroughly read through the information sheet and MLS COVID protocols and requirements. I will report to the school within 24 hours if there is any change in my child's medical condition. I understand that COVID-19 information and policy is subject to change based on NYC/SDOH updated health information related to COVID-19.	**Initial** _____
7. I agree that in the event of injury or illness, the staff member in charge of the team may act on my behalf and at my expense in obtaining medical treatment for my child.	**Initial** _____
8. I agree to be responsible for the return of all equipment issued by the school to my child.	**Initial** _____

Turn over

9. I hereby give permission for my child's photograph and information about my child's performance in activities, together with my child's name, school and grade level to be put on the school website, in accordance with the policies set forth in the MLS' Internet Acceptable Use Policy.	**Initial** _____
10. I understand that the information to be posted does not include information from my child's academic, guidance, permanent or cumulative record (i.e. grades or attendance records). I also understand that the information to be posted does not include other personally identifiable information such as my child's address, phone number, or social security number.	**Initial** _____
11. I hereby give permission for my child to be interviewed, videotaped and/or photographed by the media as it pertains to MLS athletic contests. I also hereby release the Martin Luther School, and its agents and employees, from all claims demands, liabilities whatsoever in connections with the above.	**Initial** _____
12. I hereby release, discharge, the Martin Luther School, and their employees of all claims, demands or causes of action which are in any way connected with my child's participation in this activity, except if such claims arise out of gross negligence or willful misconduct of Martin Luther School.	**Initial** _____

In an emergency, please contact me at: (_____)_____or (_____)_____.

_____ _____ _____

Print-Parent/Guardian Signature Date Signed

I have found the medical certificate submitted by student and parent to be acceptable.

_____ _____

Athletic Director Date

6.21

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ATHLETIC TRANSPORTATION WAIVER

The Martin Luther School Athletic Department states the following: Student Athletes shall be transported to and away from away contests (games and /or scrimmages) by school authorized vehicles only. Under certain circumstances or exceptional situations where it creates an inconvenience to the family, students may be excused from riding back to school from an athletic event on school authorized transportation. In such cases, the request must be ***made in writing and in advance to the student/athlete's coach.*** Should a parent approach the Head Coach at an away contest and request that their son/daughter ride home with them without advanced written notification, the head coach may agree upon receiving written release on site." ***Phone calls will not be accepted***

Section A: Parents requesting to provide transportation for their child from an AWAY contest

Name of Student Athlete _____

Name of Activity and Level _____

Location and Opponent _____

Date of Activity _____

I, (Parent/Guardian – please print) _____ will

provide transportation from my child's away athletic contest.

*Please also sign Section D on page 2.**

Section B: Parents requesting to have a designated parent to provide transportation for their child from an AWAY contest

Name of Student Athlete _____

Name of Activity and Level _____

Location and Opponent _____

Date of Activity _____

I, (Parent/Guardian – please print) _____

authorize (Designated Parent –please print) _____ to provide

transportation from my child's away athletic contest.

*Please also sign Section D on page 2.**

Section C: Parents requesting their child to travel from an AWAY contest

Name of Student Athlete _____

Name of Activity and Level _____

Location and Opponent _____

Date of Activity _____

I, (Parent/Guardian – please print) _____

give permission for my child to ***walk, take public transportation, or take a cab*** from the away athletic contest on their own. **Please also sign Section D.**

Section D

I hold Martin Luther School harmless from all liability and claims as a result of my request for the removal of my child from transportation to or from school by Martin Luther School transportation.

Signed : _____ Date _____
Parent/Guardian

****Please sign at time of pick-up only* (For Section A or B)***

Signed : _____ Date _____
Parent/Guardian

Time picked up: _____

I have verified the above student was in the custody of the parent at time of release.

Signed : _____ Date _____
Martin Luther School Employee or Coach

(For Section C)

Time Released: _____

Signed : _____ Date _____
Martin Luther School Employee or Coach

Martin Luther School

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Martin Luther School Athletics Attestation

Being an interscholastic student-athlete for Martin Luther School is a privilege and one that carries great responsibility. It is vital for the safety and health of you, your teammates, coaches, family and our school community that you follow all of the following guidelines:

- Comply with MLS, PSAA, NYSPHSAA, NYSAIS, DOH, SED, NFHS, CDC health and safety rules and protocols
- Comply with travel restrictions as directed
- Follow all rules related to face coverings, social distancing, PPE use and frequent hand washing
- Complete the MLS Health Screening and temperature check every day
- Undergo COVID testing when directed
- Report if you test Positive for COVID-19
- Report if you are required to quarantine due to close contact with someone who is positive
- Comply with direct contact tracing requirements if you are identified as positive or a contact of anyone testing positive
- **STAY HOME IF YOU FEEL SICK**
- You are required to report any symptoms of illness or injury to the coaching staff as soon as they occur as it could be a sign of a more serious health issue such as concussion or COVD-19.
- If you had a fever or vomited within 24hrs preceding training or a contest, you may not attend and must notify your coach of your absence.

I, _____ agree to comply with all of the above outlined behavior expectations.

Student-Athlete Name/Signature: _____ Grade: Date: _____

Parent Name/Signature: _____ Date:_____

Season: _____ Fall ____Winter ____ Spring

All above information is based on current and anticipated conditions and is subject to change depending on real time conditions and governmental/health department guidance/mandates.

6.21

Martin Luther School Athletic
Emergency Information Year _____

Please Print Name _____

Birth Date _____ Age _____ Grade _____

Parent/Guardian Name _____

Address _____ Phone _____

Father's ___ Mother's ___ Phone During Day _____

In an emergency, if parents cannot be contacted, notify:

_____ Phone _____

Family Doctor _____ Phone _____

Known Allergies _____

The team physician, trainer and coach may apply first aid treatment until the family doctor can be contacted. Yes ☐ No ☐

We give our consent for coaches, trainers and team physician to use their own judgement in securing medical aid and ambulance service in case the parents cannot be reached.

Yes ☐ No ☐

Parent's Signature _____ Date _____

Martin Luther School Athletic
Emergency Information Year _____

Please Print Name _____

Birth Date _____ Age _____ Grade _____

Parent/Guardian Name _____

Address _____ Phone _____

Father's ___ Mother's ___ Phone During Day _____

In an emergency, if parents cannot be contacted, notify:

_____ Phone _____

Family Doctor _____ Phone _____

Known Allergies _____

The team physician, trainer and coach may apply first aid treatment until the family doctor can be contacted. Yes ☐ No ☐

We give our consent for coaches, trainers and team physician to use their own judgement in securing medical aid and ambulance service in case the parents cannot be reached.

Yes ☐ No ☐

Parent's Signature _____ Date _____

Family Doctor _____ Phone _____

HEALTH HISTORY

	Yes	No
Kidney Injuries	☐	☐
Heart Condition/Disease	☐	☐
Diabetes	☐	☐
Asthma	☐	☐
While competing, do you wear:		
glasses	☐	☐
contacts	☐	☐

Date of last Tetnus Shot _____

Allergy to any medication: _____

Current Medications: _____

Health Insurance Plan: _____

Health Insurance ID #: _____ Group: _____

Family Doctor _____ Phone _____

HEALTH HISTORY

	Yes	No
Kidney Injuries	☐	☐
Heart Condition/Disease	☐	☐
Diabetes	☐	☐
Asthma	☐	☐
While competing, do you wear:		
glasses	☐	☐
contacts	☐	☐

Date of last Tetnus Shot _____

Allergy to any medication: _____

Current Medications: _____

Health Insurance Plan: _____

Health Insurance ID #: _____ Group: _____