1159 Abbott Road
Buffalo, New York 14220
Phone: (716) 821-1903
Fax: (716) 342-2222

Dear Parents and Guardians,

Your son/daughter who is going into **7th or 8th grade** for the 2024-2025 school year has expressed interest in joining a Global Concepts Charter Fall sports team. Sports tryouts and practice are scheduled to begin the week of Monday August 26, 2024.

The date, time and location of sports tryouts and practices will be posted on the Global Concepts website Athletics page – www.globalccs.org – please check for updates and listen to our robo-calls and follow our text alerts.

STUDENTS WHO WISH TO PARTICPATE IN A MIDDLE SCHOOL FALL SPORT ARE TO RETURN THE COMPLETED ATTACHED FORMS BY MONDAY JUNE 24, 2024 to the **Middle School Building Nurse.**

By signing below, I give my child permission to participate in the below circled sports program at Global Concept Charter High School. I understand that the practices will take place after school and will pick up my child **on time** following practice or games.

TO TRYOUT: your child **must** have a current physical (**within a year of 8/23/2024**) to participate. If you have any questions please contact Mr. Mazella at 716-939-2554 or at rmazella@globalccs.org

My child is interested in participating in the following sport(s):

7/8th Grade (Middle School) Soccer – 7/8th Grade (Cross Country)

_____ _____

Student Name Print Student Name Signature

_____ _____

Parent/Guardian Name Print Parent/Guardian Signature

Current Homeroom Teacher and Grade _____

. . . . . .

Global Concepts Charter School does not discriminate on the basis of race, religion/creed, color, national origin, gender/sex, age, disability, sexual orientation, gender identity or expression, transgender status, genetic predisposition or carrier status, veteran status, victim of domestic violence status, familial status, marital status or any other legally protected status.*

Excellence in Educational Programming

Global Concepts Charter School
Athlete Health and
Permission Release Form

1. I give permission for my son/daughter (print full name) _____ to participate on the (level/sport)_____ team for the 2024-2025 school year.
2. I understand that practices and meets will take place on and off of school property and in the community.
3. I understand that Global Concepts Charter School does not provide student accident insurance for participants in interscholastic athletics and that it is the responsibility for the parent/guardian to assume any costs through their insurance carrier.
4. I understand that participation in athletics may cause personal injury; including but **NOT** limited to sprains, strains, broken bones, cuts, wounds, scrapes, head, neck and back injuries.
5. I understand that I am financially responsible for any injuries to my son/daughter as stated in this release. I also agree to hold harmless Global Concepts Charter School and its employees and or its Board of Trustees for any such injury to my child.
6. I give permission for emergency transportation and or emergency treatment in the event of an injury incurred in connection with the athletics as stated above.

Medical Provider_____

Parent/Guardian Signature_____

Students Signature_____

Phone Number_____

Emergency Phone Number_____

Hospital Preference_____

Interval Health History for Athletics

Student Name:	DOB:
School Name: Global Concepts Charter School	Age:
Grade (check): ☐7 ☐8 ☐9 ☐10 ☐11 ☐12	Limitations: ☐ NO ☐ YES
Sport:	Date of last Health Exam:
Sport Level: ☐Modified ☐Fresh ☐ JV ☐Varsity	Date form completed:

MUST be completed and signed by Parent/Guardian - Give details to any YES answers on the last page.

SINCE YOUR CHILD'S LAST HEALTH EXAM – HAS YOUR CHILD?

GENERAL HEALTH	NO	YES
Been restricted by a health care provider from sports participation for any reason?	☐	☐
Had surgery?	☐	☐
Spent the night in a hospital?	☐	☐
Been diagnosed with mononucleosis within the last month?	☐	☐
Has only one functioning kidney?	☐	☐
Has or had a bleeding disorder?	☐	☐
Having problems with hearing or have congenital deafness?	☐	☐
Having problems with vision or only have vision in one eye?	☐	☐
Been diagnosed with a new medical condition?	☐	☐
If yes, check all that apply: ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Sickle cell trait or disease ☐ Other:		
Developed Allergies?	☐	☐
If yes, check all that apply ☐ Food ☐ Insect Bite ☐ Latex ☐ Medicine ☐ Other: ☐ Pollen		
Had anaphylaxis?	☐	☐
Carry an epinephrine auto-injector?	☐	☐
Had or has groin pain, a bulge, or a hernia?	☐	☐
DEVICES / ACCOMMODATIONS	**NO**	**YES**
Uses a brace, orthotic, or another device?	☐	☐
Has special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)?	☐	☐
Wears protective eyewear, such as goggles or a face shield?	☐	☐
Wears a hearing aid or cochlear implant?	☐	☐

Let the coach/school nurse know of any device used. Not required for contact lenses or eyeglasses.

SINCE YOUR CHILD'S LAST HEALTH EXAM – HAS YOUR CHILD?

BRAIN/HEAD INJURY HISTORY	NO	YES
Has or had a hit to the head that caused headache, dizziness, nausea, or confusion, or been told they had a concussion?	☐	☐
Received treatment for a seizure disorder or epilepsy?	☐	☐
Has or had headaches with exercise?	☐	☐
Has or had migraines?	☐	☐
BREATHING	**NO**	**YES**
Complained of getting extremely tired or short of breath during exercise?	☐	☐
Used or carries an inhaler or nebulizer?	☐	☐
Has or had wheezing or coughing frequently during or after exercise?	☐	☐
Been told by a health care provider they have asthma or exercise-induced asthma?	☐	☐
DIGESTIVE (GI) HEALTH	**NO**	**YES**
Has or had stomach or other GI problems?	☐	☐
Has an eating disorder?	☐	☐
Has a special diet or need to avoid certain foods?	☐	☐
Do you have concerns about your child's weight?	☐	☐
INJURY HISTORY	**NO**	**YES**
Been unable to move their arms or legs or had tingling, numbness, or weakness after being hit or falling?	☐	☐
Had an injury, pain, or joint swelling caused them to miss practice or a game?	☐	☐
Has or had a bone, muscle, or joint that bothers them?	☐	☐
Has or had joints that become painful, swollen, warm, or red with use?	☐	☐
Been diagnosed with a stress fracture?	☐	☐
FEMALES ONLY	**NO**	**YES**
Change in period frequency related to female athlete triad?	☐	☐

Student Name:	DOB:

SINCE YOUR CHILD'S LAST HEALTH EXAM – HAS YOUR CHILD?		
MALES ONLY	**NO**	**YES**
Has only one testicle?	☐	☐
SKIN HEALTH	**NO**	**YES**
Has any rashes, pressure sores, or other skin problems?	☐	☐
Has a herpes or MRSA skin infection?	☐	☐
COVID-19 INFORMATION	**NO**	**YES**
Child tested positive for COVID-19?	☐	☐
IF NO, STOP and go to Family Heart Health History. If **YES,** answer the questions below:		
Date of positive COVID test:		
Was your child symptomatic?	☐	☐
Did your child see a healthcare provider for their COVID-19 symptoms?	☐	☐
Was your child hospitalized for COVID?	☐	☐
Was your child diagnosed with Multisystem Inflammatory Syndrome (MISC)?	☐	☐

SINCE YOUR CHILD'S LAST HEALTH EXAM – HAS YOUR CHILD?		
HEART HEALTH	**NO**	**YES**
Had a test by a health care provider for their heart (e.g., EKG, echocardiogram, stress test)?	☐	☐
Has or had lightheadedness or dizziness during or after exercise?	☐	☐
Has or had chest pain, tightness, or pressure during or after exercise?	☐	☐
Has or had fluttering in the chest, skipped heartbeats, heart racing?	☐	☐
Been told by a healthcare provider they have or had a heart or blood vessel problem?	☐	☐

If yes, check all that apply:

- ☐ Chest Tightness or Pain
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ New fast or slow heart rate
- ☐ Has implanted cardiac defibrillator (ICD)
- ☐ Had a pacemaker implanted
- ☐ Other:
- ☐ Heart Infections
- ☐ Heart Murmur
- ☐ High Cholesterol
- ☐ Kawasaki Disease

SINCE YOUR CHILD'S LAST HEALTH EXAM - CHECK ANY NEW FAMILY HEART HEALTH HISTORY

A relative had or is currently experiencing any of the following: (Check all that apply)

- ☐ Enlarged Heart/ Hypertrophic Cardiomyopathy/ Dilated Cardiomyopathy
- ☐ Arrhythmogenic Right Ventricular Cardiomyopathy?
- ☐ Heart rhythm problems: long or short QT interval?
- ☐ Structural heart abnormality, repaired or unrepaired?
- ☐ Brugada Syndrome?
- ☐ Catecholaminergic Ventricular Tachycardia?
- ☐ Marfan Syndrome (aortic rupture)?
- ☐ Heart attack at age 50 or younger?
- ☐ Pacemaker or implanted cardiac defibrillator (ICD)?
- ☐ Known heart abnormalities or sudden death before age 50?
- ☐ Unexplained fainting, seizures, drowning, near drowning, or car accident before age 50?

If you answered **NO** to ***all*** questions, **STOP**. Sign and date below.
GO to page 3 if you answered **YES** to a question.

☐ Information on this form is NEW information since my child's last health examination.

Parent/Guardian Signature:	Date:

Student Name:	DOB:

If you answered YES to any questions, give details. Sign and date below.

Parent/Guardian Signature:	Date:

GLOBAL CONCEPTS CHARTER SCHOOL

DISCLOSURE OF PROTECTED HEALTH INFORMATION

This form allows the providers designated below to share medical information concerning your child with the school district. This information will be used to allow healthcare collaboration to maintain student safety, provide care, or create/modify programming. Please sign and date this form and make sure the school nurse has a copy.

Student Name: _____ **Date of Birth:** _____

I hereby authorize the healthcare provider(s) listed below to share information of my child with the District Physician, School Nurse, Occupational Therapist (OT), Physical Therapist (PT), School Counselor, or School Psychologist:

Name of healthcare provider: _____ **Phone:** _____

Name of healthcare provider: _____ **Phone:** _____

Name of healthcare provider: _____ **Phone:** _____

Disclosure of requested health information shall be limited to the following (*please check one*):

- ☐ **All minimum necessary health information; OR**
- ☐ **Disease-specific information as described:** _____

I UNDERSTAND THAT THIS AUTHORIZATION SHALL EXPIRE ON MY CHILD'S LAST DAY OF ENROLLMENT AT GLOBAL CONCEPTS CHARTER SCHOOL

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME BY SENDING WRITTEN NOTIFICATION TO THE HEALTHCARE PROVIDERS' OFFICE AND TO THE DISTRICT ADMINISTRATIVE BUILDING

I UNDERSTAND THAT THE REVOCATION OF THIS AUTHORIZATION IS NOT EFFECTIVE IF THE HEALTHCARE PROVIDER HAS USED THE AUTHORIZATION BEFORE RECEIVING MY WRITTEN NOTICE

I UNDERSTAND THAT ANY PROTECTED HEALTH INFORMATION DOSCLOSED AS A RESULT OF THIS AUTHORIZATION TO ANYONE NOT COVERED BY THE STATE AND FEDERAL PRIVACY LAWS AND REGULATIONS MAY BE SUBJECT TO RE-DISCLOSURE AND MAY NO LONGER BE PROTECTED BY FEDERAL AND STATE LAW

I UNDERSTAND THAT MY CHILD'S TREATMENT IS NOT DEPENDENT ON MY AGREEMENT TO RELEASE OR WITHHOLD INFORMATION

_____ _____ _____

Parent/Guardian Signature Date Relationship