



New Lebanon COVID-19 Athletic Agreement & Pledge

As a student athlete choosing to participate on a sports team at New Lebanon JR/SR High School, I know that I must take steps to stay healthy in order to protect others and promote interscholastic athletics in my school. I pledge to take responsibility for my own health to help stop the spread of COVID-19.

New Lebanon CSD has put in place preventative measures to reduce and minimize the potential exposure of athletes to COVID-19 while participating in interscholastic athletics by following applicable state and federal guidance. However, I understand that my school district cannot guarantee that a student athlete will not be exposed to COVID-19. I am aware that I may be exposed to COVID-19 while participating or attending practices and/or competitions.

In order to reduce my risk, I agree to be an active participant in maintaining my own health, wellbeing and safety, as well as the safety of others. I agree to follow all the guidelines and expectations outlined by my school.

I agree to the following:

- I will stay home if any member of my household is having any of the following symptoms:
 - Fever of 100.3°F or higher
 - Respiratory symptoms, such as dry cough or shortness of breath
 - Sore throat
 - Headache
 - Body aches
 - Chills
 - Loss of taste or smell
- If I develop the above symptoms, I agree to contact and to follow the school district's instructions which may include being tested for COVID-19 and self-quarantining while the test results are pending
- I will stay home if any member of my household has been diagnosed with COVID-19 or has a suspected diagnosis of COVID-19.
- I will stay home if I have traveled internationally or from a state with widespread community transmission of COVID-19 per the New York State Travel Advisory in the past 14 days.
- I will comply with wearing a face mask at all times, with the exception of being physically in the swimming pool.
- I will comply with daily temperature checks
- I will complete a daily COVID-19 Survey prior to attending practices and competitions or I will not be able to participate.
- I agree to immediately inform Christopher Pallozzi, athletic coordinator, at cpalozzi@newlebanoncsd.org of any known or potential exposures to COVID-19.

I have read, understand, and agree to comply with the expectations above. I acknowledge that these expectations are a condition of my participation in interscholastic athletics at New Lebanon CSD. Any failure to comply with this pledge may result in immediate removal of athletic participation privileges. I take this pledge seriously and will do my part to protect my school and community.

Student Athlete Signature

Date

Parent/Guardian Signature

Date



Consent Form for COVID-19 Testing for Athletics During 2021-22 School Year

What is this form?

We are seeking your consent to test your student-athlete for COVID-19 for participation in athletics during the 2021-22 school year.

How often would you test my child?

School staff will test students (and coaches) based on the rate of community transmission per CDC guidance. Please visit <https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/k-12-guidance.html> for more information.

What is the test?

If you consent, your child will receive a free diagnostic test for the COVID-19 virus. Collecting a specimen for testing involves inserting a small swab, similar to a Q-Tip, into the front of the nose. Please visit <https://youtu.be/AvFLbHbt1bs> for a video on this process.

What should I do when I receive my child's test results?

Test results will be available to school staff within 15 minutes. You will only be contacted if your child is positive. If your child's test results are positive, please contact your child's doctor immediately to review the results and discuss what you should do next. You should keep your child at home and inform your child's principal. If your child's test results are negative, this means that the virus was not detected in your child's specimen. If your child tests negative but has symptoms of COVID-19, or if you have concerns about your child's exposure to COVID-19, you should call your child's doctor or a local urgent care facility.

Parent/Guardian/Staff Member Information

Parent/Guardian Print Name			
Parent/Guardian Address			
Parent/Guardian Phone/Cell			
Parent/Guardian Email Address			
Best way to contact you			

Child Information

Child Print Name			
School ID # (if known)		Child Date of Birth	
Child's School			
Child Home Address			

Notification of Information Sharing

The law allows some information about your child to be shared with and among certain County and New York State agencies and their contracted service providers, including those listed below. This information will be shared only for public health purposes, which may include notifying close contacts of your child if they have been exposed to COVID-19 and taking other steps to prevent the further spread of COVID-19 in your community. Information about your child that may be shared with these agencies and service providers conducting COVID-19 Testing includes your child's name and COVID-19 test results, date of birth/age, gender, race/ethnicity, school name(s), teacher(s), cohort/pod, enrollment and attendance history, and program participation, names of other family members or guardians, address, telephone, mobile number, and email address. Sharing of information about your child will **only** be done in accordance with applicable law and policies protecting privacy and the security of your child's data.

Consent

By signing below, I attest that:

- I have signed this form freely and voluntarily, and I am legally authorized to make decisions for the child named above.
- I consent for my child to be tested for COVID-19 infection.
- I understand that my child may be tested at multiple times during the 2021-22 school year for participation in school athletics.
- I understand that my child's test results, and other information may be disclosed as permitted by law.

I understand that if I am a participant age 18 or older or may otherwise legally consent for my own health care, references to "my child" refer to me and I may sign this form on my behalf.

Signature of Parent/Guardian (if child is under age 18)		Date
Signature of Adult Staff Participant (if age 18 or over or otherwise authorized to consent)		Date



Informed Consent for Sporting Events for the New Lebanon Central School District as authorized by Medical Director within Columbia County Department of Health

READ THIS CAREFULLY – IT AFFECTS YOUR LEGAL RIGHTS

WARNING: Parent and student-athlete acknowledge and assume all risks and dangers associated with the Event or other promotions/activities before, during or after the Event ("Event Activities"), acknowledge that attendance is voluntary, and further agree that the New Lebanon CSD, together with their respective officers, directors, employees, agents, licensees, sponsors, and vendors (collectively the "Released Parties"), will not be responsible for any personal injury (including death), illness, property damage, or other loss suffered in connection with the Event/Event Activities, the negligence of any of the released parties or any other incidents caused by crowd of people. By attending the Event/Event Activities, the parent/guardian and student-athlete are deemed to have given a full release of liability to the Released Parties to the fullest extent permitted by law from any and all claims which student-athlete has or may have causes of action arising out of attendance at, observation of and/or participation in the Event/Event Activities. If parent/guardian does not wish to, or is not authorized to grant such rights, releases, and waivers on behalf of an accompanied student-athlete, the parent/guardian should immediately leave the facility with the student-athlete.

COVID-19 is an extremely contagious disease that can lead to severe illness and death in individuals of all ages and can be spread by symptomatic or asymptomatic individuals. While age and underlying conditions present more serious risk, long term effects of COVID-19 are not presently known, and even mild COVID-19 infections may be accompanied by long term consequences. At present, it cannot be predicted who will become seriously ill if infected. An inherent risk of exposure to COVID-19 exists in any public place regardless of precautions and mitigation measures that may be taken. Participation in higher risk sports places the student-athlete at risk of exposure to COVID-19. A student-athlete who becomes infected poses a significant risk to those with whom the student-athlete currently resides. By attending the event, you agree to assume all risks associated with COVID-19 and other infectious or communicable diseases, viruses, bacteria or illnesses. Parent/guardian and student athlete consent to health and security searches or screening, including but not limited to, temperature screening and COVID-19 testing, and waive all related claims, and also consents to health-related conditions for attendance, including any requirements pertaining to the wearing of masks or social distancing. Parent and student-athlete further acknowledge that a condition for continued participation in the Event will be full cooperation with case and contact investigations involving COVID-19 and any associated quarantine or isolation as required.

Student-Athlete Name

Student-Athlete Signature

Date

Parent/Guardian Signature

Date

**NEW LEBANON CENTRAL SCHOOL DISTRICT
EMERGENCY INFORMATION FOR COACH-must be completed for each sport**

Student's Name _____ Grade _____ Homeroom/Teacher _____

Mailing Address _____ Home Phone _____

911 Address _____ Age _____ Date of Birth _____

Parent Name _____ Work Location _____ Phone _____

Parent Name _____ Work Location _____ Phone _____

Step-Parent/Guardian _____ Work Location _____ Phone _____

Child lives with: (please circle): Both Parents Mother Father Other (specify) _____

Custody of Child belongs to: Both Parents Mother Father Other (specify) _____

In the event of early dismissal, illness or injury – please provide emergency contact phone numbers:

Name of relative/friend _____ Location _____ Phone _____

Name of relative/friend _____ Location _____ Phone _____

Hospital Preference _____

I give my child permission to leave practice/away games with the follow individuals (please print name)

Parent/Guardian Signature _____ Date _____

Parent/Guardian email: _____

Parent/Guardian email: _____

INTERVAL HEALTH HISTORY FORM FOR SPORTS PARTICIPATION

New Lebanon Central School District-School Health Services

THIS FORM MUST BE COMPLETED PRIOR TO THE START OF **EACH** SPORT SEASON

Student Name: _____ Age: _____

Sport: _____ Grade (check one): 7th 8th 9th 10th 11th 12th

Date of last physical _____

HEALTH HISTORY TO BE COMPLETED BY PARENT OR GUARDIAN:

Have there been any changes to your child's medical condition since their last physical? Yes/No

Since your last physical, has your child been restricted from physical activity for any reason? Yes/No

Have an ongoing medical condition? Yes/No

Asthma Diabetes Seizures Food Allergy Allergy to Insect bites Other, explain below

Carry an epinephrine auto-injector Yes/No

Use or carry an inhaler or nebulizer Yes/No

Need rescue medication for seizure disorder Yes/No

Use a brace or other equipment for sports Yes/No

Have special devices (insulin pump, glucometer hearing aids, etc) Yes/No

Recent Surgery within last 6 months; Explain below Yes/No

Ever been told by a Medical Professional that your child has had a concussion? Yes/No

Wear contacts or glasses? Yes/No

Describe the condition or situation that causes any of the above to be answered "Yes." Please indicate dates if applicable.

Medications taken at home/school include: _____

CONCUSSION INFORMATION A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by a bump, blow, or jolt to the head or body that causes the head and brain to move rapidly back and forth. Even a "ding", "getting your bell rung" or what seems to be a mild bump or blow to the head can be serious.

For additional information, visit www.cdc.gov/concussion

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 above. The answers are correct as of this date. I give my permission for my son/daughter to participate in INTERSCOLASTIC ATHLETICS. I HAVE REVIEWED THE CONCUSSION INFORMATION ABOVE.

Signed: _____ Date: ___/___/___

Reviewed by Name/Title _____ Date _____

NYSED Interval Health History for Athletics—Two Page Form

Both pages must be completed.

Student Name:		DOB:	
School Name:		Age:	
Grade (check): <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12		Level (check): <input type="checkbox"/> Modified <input type="checkbox"/> Fresh <input type="checkbox"/> JV <input type="checkbox"/> Varsity	
Sport:		Limitations: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of last health exam:		Date form completed:	

Health History to Be Completed by Parent/Guardian, Provide Details to Any Yes Answers on Back.

Medicines needed at practice and/or athletic event require the proper paperwork, contact school with questions.

Has/Does your child:		
General Health Concerns	No	Yes
1. Ever been restricted by a health care provider from sports participation for any reason?		
2. Have an ongoing medical condition? <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Seizures <input type="checkbox"/> Sickle Cell trait or disease <input type="checkbox"/> 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?		
Allergies		
11. Have a life-threatening allergy? Check any that apply: <input type="checkbox"/> Food <input type="checkbox"/> Insect Bite <input type="checkbox"/> Latex <input type="checkbox"/> Medicine <input type="checkbox"/> Pollen <input type="checkbox"/> Other		
12. Carry an epinephrine auto-injector?		
Breathing (Respiratory) Health	No	Yes
13. Ever complained of getting more tired or short of breath than his/her friends during exercise?		
14. Wheeze or cough frequently during or after exercise?		
15. Ever been told by a health care provider they have asthma?		
16. Use or carry an inhaler or nebulizer?		

Has/Does your child:		
Concussion/ Head Injury History	No	Yes
17. Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told he/she had a concussion?		
18. Ever had a head injury or concussion?		
19. Ever had headaches with exercise?		
20. Ever had any unexplained seizures?		
21. Currently receive treatment for a seizure disorder or epilepsy?		
Devices/Accommodations	No	Yes
22. Use a brace, orthotic, or other device?		
23. 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.		
24. Wear protective eyewear, such as goggles or a face shield?		
Family History	No	Yes
25. 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	No	Yes
26. Begun having her period?		
27. Age periods began:		
28. Have regular periods?		
29. Date of last menstrual period:		
Males Only	No	Yes
30. Have only one testicle?		
31. Have groin pain or a bulge or hernia in the groin?		

NYSED Interval Health History for Athletics – Page 2

Student Name: _____

School Name: _____

DOB: _____

Has/Does your child:		
Heart Health	No	Yes
32. Ever passed out during or after exercise?		
33. Ever complained of light headedness or dizziness during or after exercise?		
34. Ever complained of chest pain, tightness or pressure during or after exercise?		
35. Ever complained of fluttering in their chest, skipped beats, or their heart racing, or does he/she have a pacemaker?		
36. Ever had a test by a health care provider for his/her heart (e.g. EKG, echocardiogram stress test)?		
37. Ever been told they have a heart condition or problem by a health care provider? If so, check all that apply:		
<input type="checkbox"/> Heart infection <input type="checkbox"/> Heart Murmur <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Kawasaki Disease <input type="checkbox"/> Other: _____		
Injury History	No	Yes
38. Ever been diagnosed with a stress fracture?		

Has/Does your child:		
Injury History continued	No	Yes
39. Ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling?		
40. Ever had an injury, pain, or swelling of joint that caused him/her to miss practice or a game?		
41. Have a bone, muscle, or joint injury that bothers him/her?		
42. Have joints become painful, swollen, warm, or red with use?		
Skin Health	No	Yes
43. Currently have any rashes, pressure sores, or other skin problems?		
44. Have had a herpes or MRSA skin infections?		
Stomach Health	No	Yes
45. Ever become ill while exercising in hot weather?		
46. Have a special diet or need to avoid certain foods?		
47. Have to worry about his/her weight		
48. Have stomach problems?		
49. Ever had an eating disorder?		

COVID-19 Information	No	Yes
50. Has your child ever tested positive for COVID-19?		
51. Was your child symptomatic?		
52. Did your child see a healthcare provider (HCP) for their COVID-19 symptoms?		
53. Did your child have any cardiac symptoms (new fast or slow heart rate, chest tightness or pain, blood pressure changes, or HCP diagnosed cardiac condition)? If yes, please provide additional information.		
54. Was your child hospitalized? If yes, provide date(s)?		
If yes, was your child diagnosed with Multisystem Inflammatory syndrome (MISC)?		
If yes, is your child under a HCP's care for this?		

Please explain fully any question you answered yes to in the space below, include dates if known. Use additional pages if necessary.

Parent/Guardian Signature: _____ Date: _____