



# **HALF HOLLOW HILLS MIDDLE SCHOOL ATHLETICS**

**6<sup>TH</sup> GRADE ORIENTATION**  
**DEBRA FERRY –**  
**ATHLETIC DIRECTOR**



# THE HALF HOLLOW HILLS PHILOSOPHY

- ***THE MISSION OF THE HALF HOLLOW HILLS DISTRICT ATHLETIC PROGRAM IS TO FOSTER THE QUEST FOR EXCELLENCE BY CREATING AN EDUCATIONAL AND COMPETITIVE EXPERIENCE WITH AN ATMOSPHERE OF SPORTSMANSHIP. WE STRIVE TO DEVELOP AND REALIZE INDIVIDUAL AND TEAM POTENTIAL BY PROMOTING HIGH STANDARDS OF COMPETENCE, CHARACTER, CIVILITY AND CITIZENSHIP.***

# ATHLETIC FRAMEWORK

Competence	Character	Civility	Citizenship
Skill development	RESPONSIBILITY	RESPECT	LOYALTY
Knowledge of the game	ACCOUNTABILITY	FAIRNESS	COMMITMENT
Fitness/Conditioning	DEDICATION	CARING	TEAMWORK
Healthy Behaviors	TRUSTWORTHINESS		ROLE-MODELING
STRATEGIES	SELF-CONTROL		

# **ACADEMICS**

- **ACADEMICS COMES BEFORE ANY SPORT TEAM**
- **CHILDREN ARE IN SCHOOL TO GET AN EDUCATION**
- **ATHLETICS IS AN EXTENSION OF THE CLASSROOM**
- **ATHLETICS IS A PRIVILEGE, NOT A RIGHT. IF A STUDENT IS NOT PERFORMING TO THEIR ABILITY IN THE CLASSROOM, HE/SHE WILL JEOPARDIZE THEIR SEASON**
- **WE ARE LOOKING TO DEVELOP WELL ROUNDED *STUDENT – ATHLETES***

# **STUDENT- ATHLETE** **RESPONSIBILITIES**

- **BULLYING -BEING A GOOD TEAM MEMBER**
- **SCHOOL BEHAVIOR**
- **LOCKER ROOM RESPONSIBILITIES**
- **MAINTAIN GOOD ACADEMIC STANDING**
- **ALL ISSUED EQUIPMENT IS THE RESPONSIBILITY OF THE ATHLETE. ANY LOST UNIFORM OR PIECE OF EQUIPMENT WILL HAVE TO BE REPLACED AT THEIR EXPENSE – INDEBTED LIST**
- **ATTEND ALL PRACTICES AND GAMES. INTERSCHOLASTIC ATHLETICS IS NOT INTRAMURALS**



# **SOCIAL MEDIA ~ WHAT IS YOUR CHILD USING? DO YOU KNOW?**

- **72% OF TEENS REPORT BEING CYBERBULLIED IN THE LAST YEAR**
- **4/5 TEENS SLEEP WITH PHONE WITHIN REACH**
- **TEENS AVERAGE ONLY 42 MINUTES OF PHYSICAL ACTIVITY A DAY**
- **94% OF PARENTS SAY THEY HAVE SPOKEN TO THEIR CHILDREN ABOUT APPROPRIATE/INAPPROPRIATE ONLINE BEHAVIOR**
- **SNAPCHAT ~ FACEBOOK ~ INSTAGRAM ~ TWITTER ~ KIK ~ PINTEREST ~ VINE ~ TUMBLR ~ OOVVOO ~**

# **SPORTSMANSHIP**

- **SPORTSMANSHIP INVOLVES APPROPRIATE RESPECT TOWARDS COACHES, FELLOW PLAYERS, OPPONENTS, OFFICIALS AND SPECTATORS. DISREGARD FOR THIS WILL RESULT IN DISCIPLINARY ACTION.**
- **HERE AT HALF HOLLOW HILLS OUR ATHLETES ARE TAUGHT TO CONDUCT THEMSELVES WITH CLASS AND DIGNITY.**
- **SPECTATOR SPORTSMANSHIP – CHEER FOR HHH NOT AGAINST THE OPPONENT**

# **TIPS TO MAKE ATHLETICS A POSITIVE EXPERIENCE FOR YOUR CHILD**

- **BE A CHEERLEADER, NOT A COACH. RESIST THE POST-GAME ANALYSIS. “PARENTAL PRAISE OPENS THE DOORS OF COMMUNICATION AND MOTIVATES.... CRITICISM CAN DO THE OPPOSITE.”**
- **ENCOURAGE SPORTS SAMPLING. “DIFFERENT PERSONALITIES, ABILITIES AND DEVELOPMENTAL LEVELS MIGHT BE A BETTER MATCH WITH DIFFERENT SPORTS,”**
- **MULTI-SPORT PLAY HAS ALSO BEEN FOUND TO REDUCE BURNOUT AND OVERUSE INJURIES.**



# **“EARLY SPECIALIZATION”**

- **STUDIES** OF COLLEGE-LEVEL AND OLYMPIC ATHLETES FOUND THAT THE MAJORITY OF THEM PLAYED MULTIPLE SPORTS GROWING UP AND DID NOT SPECIALIZE EARLY
- **RESEARCH** SHOWS THERE ARE PHYSICAL RISKS INVOLVED WITH SPECIALIZATION.
- **70% OF YOUNG ATHLETES DROP OUT OF SPORTS BEFORE THEY ARE 13. THEY CITE PRESSURE AS THE MOST OVERRIDING REASON.**

# **PARENTAL PERSPECTIVE**

- **TEACH AND DEVELOP SKILLS**
- **LEARN TO WORK WITH OTHERS**
- **WIN CHAMPIONSHIPS**
- **SCHOLARSHIP OPPORTUNITIES**

# **REALITY OF ATHLETICS**

- **ONLY 2% OF GRADUATING SENIORS NATIONWIDE RECEIVE ATHLETIC SCHOLARSHIPS.**
- **1% OF THOSE 2% ATHLETES MENTIONED ABOVE GO ON TO PROFESSIONAL SPORTS.**
- **IF ATHLETICS PROVIDES FOR YOUR SON/ DAUGHTER AN ENTRANCE INTO AN INSTITUTION THEY MIGHT NOT HAVE NORMALLY QUALIFIED FOR..... IT SERVED THEM WELL.**

# CANDLEWOOD AND WEST HOLLOW ATHLETICS

## FALL

**START DATE:**

**SEPT. 4<sup>TH</sup>**

<i>Field Hockey 7/8 Grade (one team)</i>
<i>Football 8<sup>th</sup> Grade</i>
<i>Football 7<sup>th</sup> Grade</i>
<i>Boys Soccer ~ 2 teams of equal strength</i>
<i>Girls Soccer ~ 2 teams of equal strength</i>
<i>X-Country B/G 7/8 (one team)</i>

# CANDLEWOOD AND WEST HOLLOW ATHLETICS

**EARLY WINTER START DATE: NOV. 5<sup>TH</sup>**

## WINTER

**LATE WINTER START DATE: JAN. 22<sup>ND</sup>**

<u><i>Early Winter Sports</i></u>
<i>Boys Basketball (2 teams of equal strength)</i>
<i>Volleyball (2 teams of equal strength)</i>
<u><i>Late Winter Sports</i></u>
<i>Girls Basketball (2 teams of equal strength)</i>
<i>Wrestling 7/8</i>
<i>Volleyball 7/8<sup>th</sup> Grade Boys</i>



# CANDLEWOOD AND WEST HOLLOW ATHLETICS

## SPRING

**SPRING START DATE: MARCH 25<sup>TH</sup>**

<i><b>Spring Sport</b></i>
<i>Baseball (2 teams of equal strength)</i>
<i>Lacrosse 7/8<sup>th</sup> Grade Boys</i>
<i>Lacrosse 7/8<sup>th</sup> Grade Girls</i>
<i>Softball (2 teams of equal strength)</i>
<i>Spring 7/8<sup>th</sup> Grade Boys Track</i>
<i>Spring 7/8<sup>th</sup> Grade Girls Track</i>
<i>Swim &amp; Dive 7/8<sup>th</sup> Grade Boys and Girls @ HSW</i>

# **MS ATHLETICS**

- **PRACTICE TIMES: MONDAY – SATURDAY**
  - **MONDAY - FRIDAY 2:50 – 4:30**
- **LATE BUS: 4:45**
- **TRY-OUTS – SOME TEAMS HAVE TO CUT SOME DO NOT**
- **TRANSPORTATION – ATHLETES MUST RIDE THE BUS TO AND FROM CONTEST**
- **INJURIES – MUST REPORT TO COACH / NURSE**
- **COMMUNICATION WITH COACHES AND VICE VERSA**
- **MEDICAL CLEARANCES (YEARLY PHYSICALS/**

# **MEDICAL CLEARANCE DATES:** HAVE YOUR CHILD STOP IN THE NURSES OFFICE FOR PAPERWORK OR CALL THE NURSES OFFICE

- **CANDLEWOOD – PHONE # 592-3301**

- **BOYS – TBD**
- **GIRLS – MAY 22<sup>ND</sup> & JUNE 6<sup>TH</sup>**

- **WEST HOLLOW – PHONE # 592-3401**

- **BOYS – MAY 30<sup>TH</sup> & JUNE 6<sup>TH</sup>**
- **GIRLS – JUNE 1<sup>ST</sup> & JUNE 8<sup>TH</sup>**

# SCHOOL NURSE INFORMATION

- **CANDLEWOOD**

- **NURSE:**

- **EVANNE ORLEAN EMAIL:**

- **[EORLEAN@HHH.K12.NY.US](mailto:EORLEAN@HHH.K12.NY.US)**

- **WEBSITE – CLICK [HERE](#)**

- **PHONE - 592-3301**

- **WEST HOLLOW**

- **NURSES:**

- **KAREN DUENAS**

- **EMAIL – [KDUENAS@HHH.K12.NY.US](mailto:KDUENAS@HHH.K12.NY.US)**

- **DONNA INGOGLIA**

- **EMAIL: [DINGOGLIA@HHH.K12.NY.US](mailto:DINGOGLIA@HHH.K12.NY.US)**

- **WEBSITE – CLICK [HERE](#)**

- **PHONE – 592-3401**

# STUDENT HEALTH EXAM FORM (YELLOW)

- **SPORTS PHYSICAL FORM**
- **ONCE A YEAR**
- **BY DOCTOR**

Half Hollow Hills Central School District					
STUDENT HEALTH EXAMINATION FORM (To be completed by private health care provider or school medical director)					
Note: NYSED requires an annual physical exam for new entrants and students in Grades pre-K or K, 2, 4, 7 & 10, interscholastic sports and working papers					
Name: _____	DOB: _____	Gender: <input type="checkbox"/> M <input type="checkbox"/> F			
School: _____	Grade: _____	<input type="checkbox"/> N/A	Exam Date: _____		
<b>IMMUNIZATIONS</b>					
<input type="checkbox"/> Immunization record attached	<input type="checkbox"/> Immunizations received today: _____				
<input type="checkbox"/> Immunizations reported on NYSHS	<input type="checkbox"/> Will return on: _____ to receive: _____				
<input type="checkbox"/> No immunizations received today					
<b>HEALTH HISTORY</b>					
<input type="checkbox"/> Asthma: <input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent	<input type="checkbox"/> Asthma Action Plan Attached				
<input type="checkbox"/> Diabetes: <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2	<input type="checkbox"/> Hyperlipidemia	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Diabetes Medical Mgmt Plan Attached		
<input type="checkbox"/> Seizures: Type: _____ Last Occurrence: _____	<input type="checkbox"/> Emergency Care Plan Attached				
<input type="checkbox"/> Allergies: <input type="checkbox"/> Non Life-Threatening <input type="checkbox"/> Life-Threatening	<input type="checkbox"/> Emergency Care Plan Attached				
Type: <input type="checkbox"/> Food <input type="checkbox"/> Insect <input type="checkbox"/> Latex <input type="checkbox"/> Medication <input type="checkbox"/> Seasonal/Environmental <input type="checkbox"/> Other: _____					
Allergen(s): _____					
<input type="checkbox"/> History of Anaphylaxis: Last occurrence: _____ Previous symptoms: _____					
Treatment prescribed: <input type="checkbox"/> None <input type="checkbox"/> Antihistamine <input type="checkbox"/> Epinephrine Autoinjector					
Significant Medical/Surgical Information:	Positive	Negative	Not Done	Date	
Sickle Cell Screen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
PPV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Elevated Lead:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Vision one eye only <input type="checkbox"/> One functioning kidney <input type="checkbox"/> One testicle <input type="checkbox"/> Concussion - Last occurrence: _____					
<b>PHYSICAL EXAMINATION</b>					
Height: _____	Weight: _____	BP: _____	Pulse: _____	Respirations: _____	
Scoliosis: <input type="checkbox"/> Negative <input type="checkbox"/> Positive	Degree of deviation: _____		Vision	Right	Left
Angle of trunk rotation via scoliometer: _____			Distance acuity		Refer
Weight Status Category (BMI Percentile):			Distance acuity with lenses		Refer
<input type="checkbox"/> <5th <input type="checkbox"/> 85th - 94th			Vision - near vision		Refer
<input type="checkbox"/> 5th - 49th <input type="checkbox"/> 95th - 98th			Vision - color perception	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	Refer
<input type="checkbox"/> 50th - 94th <input type="checkbox"/> 99th & higher			Hearing	Right	Left
			<input type="checkbox"/> 20 db sweep screen both ears		Refer
Check developmental stage (ONLY for Athletic Placement Process for 7th & 8th graders): Tanner: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V					
<input type="checkbox"/> SYSTEM REVIEW AND EXAM ENTIRELY NORMAL <input type="checkbox"/> Additional information attached					
Specify any abnormalities: _____					
Parent/Guardian Signature: _____					



# PRE-PARTICIPATION FORM (YELLOW)

PRE-PARTICIPATION/INTERVAL ATHLETIC HEALTH HISTORY – Two Page Form		
School Name: _____		
Student Name: _____		DOB: ____/____/____
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		
Sport: _____		Level (check): <input type="checkbox"/> Varsity <input type="checkbox"/> JV
Date of last health exam: ____/____/____ Limitations: <input type="checkbox"/> Yes <input type="checkbox"/> No Date form completed ____/____/____		
<b>Health History To Be Completed By Parent/Guardian</b>		
<i>Answer questions below to indicate if your child has or has ever had the following and provide details to any yes answer on back:</i>		
<b>Question</b>	<b>YES</b>	<b>NO</b>
Has a doctor or nurse practitioner (a health care provider) ever restricted his/her participation in sports for any reason?		
Does s/he have an ongoing medical condition? Please check below: <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Seizures <input type="checkbox"/> Other <input type="checkbox"/> Sickle Cell trait or disease		
Has s/he ever had surgery?		
Has s/he ever spent the night in a hospital?		
Does s/he have a life threatening allergy? Please check below: <input type="checkbox"/> Medication <input type="checkbox"/> Food <input type="checkbox"/> Insect bites <input type="checkbox"/> Pollen <input type="checkbox"/> Latex <input type="checkbox"/> Other		
Does s/he carry an Epi-pen (epinephrine)?		
Has s/he ever passed out during or after exercise?		
Has s/he ever complained of light headedness or dizziness during or after exercise?		
Has s/he ever complained of chest pain, tightness or pressure during or after exercise?		
Has s/he ever complained of fluttering in their chest, skipped beats, or their heart racing, or does s/he have a pacemaker?		
Has a health care provider ever ordered a test for his/her heart? (ex. EKG, echocardiogram, stress test)		
Has s/he been told s/he has a heart condition or problem?		
Has s/he ever had high or low blood pressure?		
Has s/he ever complained of getting more tired or short of breath than his/her friends during exercise?		
Does s/he wheeze or cough frequently during or after exercise?		
Has a health care provider ever said s/he has asthma?		
Does s/he use or carry an inhaler or nebulizer?		
Has s/he ever become ill while exercising in hot weather?		
Is s/he on a special diet or have to avoid certain foods?		
Do you have an Insulin Pump/Sensor?		
Does s/he worry about their weight?		
<b>Question</b>	<b>YES</b>	<b>NO</b>
Does she/he have stomach problems?		
Has s/he ever had a hit to the head that caused a headache, dizziness, nausea, or confusion, or been told s/he had a concussion?		
Does s/he ever have headaches with exercise?		
Has s/he ever had a seizure?		
Is s/he currently being treated for a seizure disorder or epilepsy?		
Has s/he ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling?		
Has s/he ever an injury, pain, or swelling of joint that caused him/her to miss practice or a game?		
Does s/he use a brace, orthotic or other device?		
Does s/he have any problems with his/her hearing or wear hearing aides?		
Does s/he have any problems with his/her vision or have vision in one eye only?		
Does s/he wear glasses or contacts?		
Has s/he ever had a hernia?		
Does s/he have only 1 functioning kidney?		
Does s/he have a bleeding disorder?		
<b>Females Only</b>	<b>YES</b>	<b>NO</b>
Has she had her period? At what age did it begin?		
How often does she get her period?		
Date of last menstrual period		
<b>Males Only</b>	<b>YES</b>	<b>NO</b>
Does he have only one testicle?		
<b>Family History</b>	<b>YES</b>	<b>NO</b>
Has any relative been diagnosed with a heart condition or developed hypertrophic cardiomyopathy, Marfan Syndrome, right ventricular cardiomyopathy, long QT or short QT syndrome, Brugada Syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
Has any relative died suddenly before the age of 50 from unknown or heart related cause?		

- ONE PER YEAR
- EVERY YEAR

# INTERVAL HEALTH HISTORY FORM (GREEN FORM)

- **PER SEASON**
- **NOT 30 DAYS PRIOR**

**IMPORTANT UPDATE:** This form is an addendum to your child's current physical on file. A current physical is one that is performed within 12 months of the first day of sports practice. If the physical was performed more than 30 days before the first day of practice, this form must be completed. **PLEASE NOTE: this form CANNOT be completed and signed more than 30 days before the first date of practice.**

Student \_\_\_\_\_ Grade \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Sport: \_\_\_\_\_ (circle one): Male \_\_\_\_\_ Female \_\_\_\_\_

**HISTORY SINCE LAST PHYSICAL – TO BE COMPLETED BY THE PARENT/GUARDIAN**  
Date of last physical exam (month and year is sufficient) \_\_\_\_\_  
Since the last physical exam, has your child \_\_\_\_\_ **DATE** \_\_\_\_\_

1. Experienced any type of head injury or concussion requiring medical attention?	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
2. Received any injury requiring medical attention?	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
3. Had any surgical operations, joint injuries, or fractured bones?	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
4. Been treated in a hospital or emergency room/walk-in?	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
5. Been diagnosed with any condition requiring medical attention?	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
6. Missed any practices and/or games due to illness or injury?	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
7. Been absent from school for 5 or more consecutive days due to accident or illness that required medical attention?	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
8. Had an injury or illness that has prevented them from exercise or other athletic activities?	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
9. Been prescribed any medication by a doctor?	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
10. Experienced any feelings of faintness or dizziness after exertion?	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
11. Had a change in vision (such as wearing glasses or contact lenses)?	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
12. Developed any allergies?	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____

**FEMALES ONLY:** Date of Last Menstruation - \_\_\_\_\_  
Please describe the conditions or situation that caused any questions listed above to be answered "YES": \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Note: "Yes" to any of the above question does not mean automatic disqualification from an interscholastic activity. However, it will require a review and approval by the school physician before the student can report to practice and tryout.*

**PARENT CONSENT FORM: PARENTAL SIGNATURE REQUIRED:**  
I, the undersigned, clearly understand these questions are asked in order to determine if my child can safely participate in the interscholastic activity listed below. All answers are correct and of this date. I hereby give my consent for \_\_\_\_\_ to participate in \_\_\_\_\_ practice and contests  
(Student's Name) (Sport Activity)

Home Telephone #: \_\_\_\_\_  
Work Telephone #: \_\_\_\_\_  
Cell Telephone #: \_\_\_\_\_  
DATE: \_\_\_\_\_ SIGNATURE OF PARENT/GUARDIAN: \_\_\_\_\_

# MEDICATION FORM

## PROVIDER AND PARENT PERMISSIONS REQUIRED FOR INDEPENDENT MEDICATION USE AND CARRY

**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 use and carry their medication as required by NYS law. A **provider order** and **parent/guardian permission** is 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.

• **EPINEPHRINE**

• **INSULIN**

• **INHALER**

• **DOCTOR & PARENT**

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

### Health Care Provider Permission for Independent Use and Carry:

I attest that this student has demonstrated to me that they 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 at any school/school sponsored activity with no supervision by school staff. 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)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Parent/Guardian Permission for Independent Use and Carry:

I agree that my child can use their medication effectively and may use and carry this medication independently at any school/school sponsored activity with no supervision by school staff.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# THE ALL IMPORTANT “WHITE CARD”

**WHEN ALL THE ATHLETE’S PAPERWORK IS  
COMPLETED ~ EACH ATHLETE RECEIVES A  
(STAMPED) “WHITE CARD” ~ THIS IS THEIR  
PASS TO PLAY!**

HALF HOLLOW HILLS CENTRAL SCHOOL DISTRICT ATHLETIC DEPARTMENT – EMERGENCY CARD

Name \_\_\_\_\_ Male or Female \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_  
(Last name, First name) (circle one) (set of sports season)

Address \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
(street) (city) (state) (zip code)

Father \_\_\_\_\_ Phone h. \_\_\_\_\_ C. \_\_\_\_\_ W. \_\_\_\_\_  
Mother \_\_\_\_\_ Phone h. \_\_\_\_\_ C. \_\_\_\_\_ W. \_\_\_\_\_

EA Mail: Mother \_\_\_\_\_ Father \_\_\_\_\_ Student \_\_\_\_\_

Emergency Contacts (other than parent)

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ Phone h. \_\_\_\_\_ C. \_\_\_\_\_  
List Allergies \_\_\_\_\_

\*Medical Concerns \_\_\_\_\_

Advanced Placement Process: JV Varsity \_\_\_\_\_ Sport \_\_\_\_\_ Exam Date \_\_\_\_\_  
Athletic Director \_\_\_\_\_ Nurse \_\_\_\_\_  
(signature)

Debra A. Ferry, Director of Athletics (516) 592-3885 – [dferry@hhhs.k12.ny.us](mailto:dferry@hhhs.k12.ny.us)

Name \_\_\_\_\_ Locker Number \_\_\_\_\_  
Coach \_\_\_\_\_ Sport \_\_\_\_\_ Date of Issue \_\_\_\_\_

Item Issued	Number	Return Date	Item Issued	Number	Return Date
Game Jersey - Color			Sweat Shirt		
Game Jersey - White			Sweat Pant		
Game Pant - Color			Warm-up Jacket		
Game Pant - White			Warm-up Pant		
Sock/Stirrup - Color			Knee Pads		
Sock/Stirrup - White			Helmet		
Practice Pant			Shoulder Pads		
Practice Shirt			Girdle		
Singlet			Goalie Equipment		

I agree to replace all items lost, misplaced, or destroyed while issued to me.

Signature of Student \_\_\_\_\_

Revised 1/18

# ATHLETIC OFFICE INFORMATION

- **ATHLETIC DIRECTOR**

- **DEBRA FERRY**

- **PHONE - 592-3066**

- **E-MAIL – [DFERRY@HHH.K12.NY.US](mailto:DFERRY@HHH.K12.NY.US)**

- **ADMINISTRATIVE ASSISTANT**

- **MICHELE FELDMAN**

- **PHONE – 592-3066**

- **E-MAIL – [MFELDMAN@HHH.K12.NY.US](mailto:MFELDMAN@HHH.K12.NY.US)**



# WHAT IS IT ALL ABOUT?

