FRANKLIN ELEMENTARY SCHOOL
206 POND RD
N. FRANKLIN, CT 06254

860-642-7063
MAIN OFFICE

860-642-7241
FAX

Dear Parents:

This letter is in regards to "Sports Physicals". It is better titled **a "Pre-participation sports evaluation".** It has been brought to my attention that many Physician Offices' are completing the "Blue Form" as if it is a mandated Physical. A sport's evaluation is not mandated by the state however it is the policy that Franklin's Board of Education has chosen to institute. The form that will be utilized for the sports evaluation/permission slip will be made available in the Main & Health Office as well as the Franklin website. The form is going to be White and is titled "Pre-participation Sports Evaluation" and is to be completed for each sport played.

Students in grades 4-8 are eligible for sports participation at FES. The revised (Tri-fold version) Blue Health Assessment form is now accepted for participation in after school sports. Please note: the date of exam must be within 13 months and remain valid throughout the entire sports season.

Guidelines have been created by the *Connecticut Interscholastic Athletic Conference* (CIAC) to address High & Middle School Level Athletic Programs. According to the CIAC guidelines all students **must** have a physical completed every **13 months**. The *date* of the evaluation is required to be valid throughout the entire sports season. **FES board policy requires the Pre-participation sports evaluation/permission slip to be completed per each sport played.**

It is vital that these guidelines are followed to ensure the safety of our students. ***If the evaluation is not completed by the start of tryouts and/or practices the student will not be permitted to participate.***

If your child has any interest in participating in a school sport please contact the health office so that I can let you know if an Evaluation is required. My goal is to provide parents/guardians with enough notice to complete the necessary paperwork and the students will have the opportunity to start their sport of interest on time.

*In the event your child requires an inhaler and/or Epi Pen during the entire sports season, The State of Connecticut medication Administration policy is now requiring that a separate Inhaler/Epi Pen needs to be provided for after school sports activities. Medication will no longer be provided from the Health Office. The Head Coach will be have a first aid bag at all times. The medication can be stored in this bag for the entire season. The student is permitted to have the epi/inhaler with them if authorization is provided by medical provider & parent/guardian.

Sincerely,
Bob Austin, Principal
Alden Miner, Athletic Director
Sheri Salpietro RN, FES School Nurse

FRANKLIN ELEMENTARY SCHOOL
206 POND RD
N. FRANKLIN, CT 06254

860~642~7063
MAIN OFFICE

860~642~7241
FAX

Dear Parents:

Your child has expressed an interest in participating in our school's athletic program. Before your child may participate it is required that proof of a physical examination done within the past year be on file in the nurse's office. You and your child must also complete this Sports Participation Questionnaire before each sports season.

Name: ____________________________ Date of Birth:_____________Grade:____________

Address:____

Sports Being played____

1. Do you have any allergies? (Food, Drug, Insects, etc.) Yes ____ Please Explain below. No

____

2. Are you currently taking any medications, prescribed or over the counter? This includes supplements. Yes ____ Please list below. No ____

____

3. Are you presently being treated for any condition by a physician or other health care professional? Yes ____No_____

4. Have you ever been advised by a doctor not to participate in any sport: Yes __ No___

5. Do you have any chronic conditions, disorders or diseases? Please specify below.

____

6. Lastly, if there are any medical concerns you may have that have not been addressed by the previous questions please state them below:

____

STUDENT AND PARENT OR GUARDIAN:

We hereby state that we have reviewed this medical history and found the information supplied within to be correct to the best of our knowledge. Also in case of an emergency we give the school permission to call 911 and have our child transported to a Hospital.

______________________	______________________
Hospital of Choice	Student Signature Date
______________________	______________________
Contact Number	Parent Signature Date

FRANKLIN ELEMENTARY SCHOOL
206 POND ROAD
NORTH FRANKLIN, CT 06254

860~642~7063
MAIN OFFICE

860~642~7256
FAX

Dear Parent/Guardian:

According to the State of Connecticut Medication Administration Guidelines in regards to after school sports. Students are now required to obtain an MD order and provide an additional inhaler or Epi-pen during the sports season. This medication will be returned when the season has been completed. The health office is no longer permitted to provide medication coverage for after school sports.

Please contact the health office with any questions or concerns.

Thank you

Sheri Salpietro, R.N.
School Nurse

FRANKLIN PUBLIC SCHOOL
Franklin, Connecticut
AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINES BY SCHOOL PERSONNEL

The Connecticut State Law and Regulations require a physician's, dentist's, advanced practice registered nurse or physician's assistant's written order and parent or guardian's authorization for a nurse to administer medications or in her absence the principal, teacher, licensed physical or occupational therapist of a school or a coach to administer medications. Medications must be in pharmacy prepared containers and labeled with name of child, name of drug, strength, dosage, frequency, physician's or dentist's name and date of original prescription.

PHYSICIAN OR DENTIST'S ORDER

Name of Child ______________________ Date ______________________

Date of Birth ______________________

Allergies to Medications ______________________

Condition for which drug is being administered during school hours ______________________

____

DRUG: name, dose and method of administration
This medication may be self-administered. ______________________ Physician's signature.
Time of administration ______________________
Medication shall be administered from ______________ to ______________
(Date) (Date)

Relevant side effects to be observed, if any ______________________

____

If there are side effects, plan for management ______________________

____

Is this a controlled drug? ______________ If yes, DEA number ______________
Physician's/Dentist's Name ______________ Tel. ______________
(Type or print)
Address ______________________

Physician or Dentist's Signature ______________________ Date ______________

Nurse/Principal/Teacher ______________________ Date ______________

AUTHORIZATION BY PARENT/GUARDIAN FOR THE ADMINISTRATION OF THE ABOVE MEDICATION BY SCHOOL PERSONNEL:

Date: ______________

To School Personnel:

I hereby request that the above medication, ordered by the physician/dentist for by child ______________,
_____ be administered by school personnel _____ be self-administered. I understand that I must supply the school with the prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist and will provide no more than a 45 school day supply of said medication.
I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.

Name: ______________________
(Type or Print)

Signature: ______________________ Relationship to child: ______________________

Address: ______________________ Telephone: ______________________