

HOLY TRINITY HIGH SCHOOL – PARENT CONSENT/HEALTH HISTORY FORM PAGE 2

Student Name: _____

School Name: _____

DOB: _____

Has/Does your child:

Heart Health	No	Yes
32. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
33. Ever complained of light headedness or dizziness during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
34. Ever complained of chest pain, tightness or pressure during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
35. Ever complained of fluttering in their chest, skipped beats, or their heart racing, or does he/she have a pacemaker?	<input type="checkbox"/>	<input type="checkbox"/>
36. Ever had a test by a health care provider for his/her heart (e.g. EKG, echocardiogram stress test)?	<input type="checkbox"/>	<input type="checkbox"/>
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: _____	<input type="checkbox"/>	<input type="checkbox"/>
Injury History	No	Yes
38. Ever been diagnosed with a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>

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?	<input type="checkbox"/>	<input type="checkbox"/>
40. Ever had an injury, pain, or swelling of joint that caused him/her to miss practice or a game?	<input type="checkbox"/>	<input type="checkbox"/>
41. Have a bone, muscle, or joint injury that bothers him/her?	<input type="checkbox"/>	<input type="checkbox"/>
42. Have joints become painful, swollen, warm, or red with use?	<input type="checkbox"/>	<input type="checkbox"/>
Skin Health	No	Yes
43. Currently have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
44. Have had a herpes or MRSA skin infections?	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Health	No	Yes
45. Ever become ill while exercising in hot weather?	<input type="checkbox"/>	<input type="checkbox"/>
46. Have a special diet or need to avoid certain foods?	<input type="checkbox"/>	<input type="checkbox"/>
47. Have to worry about his/her weight?	<input type="checkbox"/>	<input type="checkbox"/>
48. Have stomach problems?	<input type="checkbox"/>	<input type="checkbox"/>
49. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>

COVID-19 Information

COVID-19 Information	No	Yes
50. Has your child ever tested positive for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
51. Was your child symptomatic?	<input type="checkbox"/>	<input type="checkbox"/>
52. Did your child see a healthcare provider (HCP) for their COVID-19 symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>
54. Was your child hospitalized? If yes, provide date(s)?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, was your child diagnosed with Multisystem Inflammatory syndrome (MISC)?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, is your child under a HCP's care for this?	<input type="checkbox"/>	<input type="checkbox"/>

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: _____

Emergency Contact - Name _____

Number: _____