

INTERVAL HEALTH HISTORY FOR SPORTS PARTICIPATION

SCHOOL NAME: _____

Prior to the start of tryout sessions or practice at the beginning of each season, a health history review for each athlete must be conducted unless the student received a full medical examination within 30 days of the start of the season.

PART A: TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE

Student: _____ Age: _____

Grade (check): 6 7 8 9 10 11 12 Date of Birth: ____/____/____

Sport: _____ Level (check): Varsity JV Fresh Jr. High

Date of last health appraisal: ____/____/____ Limitations: Yes No

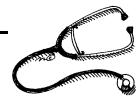
PART B: TO BE COMPLETED BY THE PARENT OR GUARDIAN

Note: "Yes" to any of these questions does not mean automatic disqualification from the athletic activity indicated in PART A above. However, it may require a review and approval by the school physician before the student can report to practice or tryouts.

HISTORY SINCE LAST HEALTH APPRAISAL:

- | | |
|---|--|
| Allergies (Bee Sting/Medications/Food/Latex, etc.) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does the student carry an Epi-pen® for a life-threatening allergy? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does the student carry an inhaler? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Concussion/Head injury/Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Recent injury that requires medical attention or protective equipment? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Recent illness lasting longer than one week (i.e. Mono) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Currently taking medications | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes/Hypoglycemia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Condition/Blood Pressure Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heat Exhaustion or Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hearing Impairment | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Tendency/Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Recent Surgery or Hospitalization | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Kidney/Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Contact Lenses/Vision problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is there any medical condition that might be aggravated by playing sports? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Any ongoing medical conditions? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Any complaints of chest discomfort, racing heart, light headiness, dizziness during or after exercise? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 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? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Has any relative died suddenly before the age of 50 from unknown or heart related cause? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Part D Parental Permission/Signature for all students. See page 2.



PART C: TO BE COMPLETED BY PARENT OR GUARDIAN

Describe the condition or situation that caused any questions in PART B to be answered "YES".

Horizontal lines for writing the answer to Part C.

PART D: 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 in PART A of this form. The answers are correct as of this date and he/she has my permission to participate.

SIGNED: _____ DATE: ____/____/____

PLEASE RETURN TO THE SCHOOL HEALTH OFFICE

PART E: TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE

Sports Participation: Approved Referred to School Physician

Signed: _____ Date: ____/____/____
School Health Office

If referred to the School Physician: Requalified Disqualified

Signed: _____ Date: ____/____/____
School Physician