ROCKVILLE CENTRE UNION FREE SCHOOL DISTRICT
Rockville Centre, New York 11570

INTERVAL HEALTH HISTORY FOR SPORTS PARTICIPATION

Student's name: ____________________________ NAME OF SCHOOL: ______________________

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

PART A – **TO BE COMPLETED BY THE PARENT OR PERSON IN PARENTAL RELATION**
Student's Age: ____________________________ Student's date of Birth: ______________________

Date of last health appraisal/examination: ______________/____________/______________________
DAY MONTH YEAR

Grade (check): ❒ 7th ❒ 8th ❒ 9TH ❒ 10TH ❒ 11TH ❒ 12TH

Sport: ____

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

The answers to the questions on this form will be held in the school health office and will be kept confidential.

HISTORY SINCE LAST HEALTH APPRAISAL

If the answer to any of the following questions is "YES", please describe the condition or situation that prompted your answer in PART B on the reverse side of this form.

(Please check either yes or no to the following questions:)

		YES	NO
1.	Any injuries requiring medical attention?		
2.	Any illness lasting more than five (5) days?		
3.	Taking medicine or under a provider's care at this time?		
4.	Any feeling of faintness, dizziness, or fatigue after exercise or exertion?		
5.	Change in wearing glasses or contact lenses?		
6.	Any surgical operations or fractures?		
7.	Any treatment in a hospital or emergency room?		
8.	Developed any allergies?		
9.	Any chronic disease?		

PART B – **TO BE COMPLETED BY PARENT OR PERSON IN PARENTAL RELATION**

Describe the condition or situation that caused any questions in PART B to be answered with “YES”:

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PART C – **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.

I have received, read, and understand the Concussion student and parent information document. I understand the signs and symptoms of a concussion and give permission for the Certified Athletic Trainer (if present) to conduct a sideline assessment to determine whether further medical care is necessary if there is suspicion that my child has withstood a head injury at an athletic event. I understand that only school personnel can perform my child’s return to play protocol.

Signature of Parent/Person in parental relation: ___________________________ Date: ____/_______/

PLEASE RETURN TO THE SCHOOL HEALTH OFFICE

PART D – TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE

Sports Participation (check):

❒ Approved ❒ Referred to School Physician or Nurse Practitioner

Reason: ______________________________

Signature: ________________________________ Date: ______/________/________

School Health Official

Sport: ___________________________________ Level (check): ❒ Varsity ❒ JV ❒ Middle School

If referred to the School Physician or Nurse Practitioner (check): ❒ Requalified ❒ Disqualified

Signature: ________________________________ Date: ______/________/________

School Physician or Nurse Practitioner

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