



Our Lady of the Hamptons Regional Catholic School
 160 North Main Street, Southampton, New York 11968

Telephone 631-283-9140

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Student Name: _____ DOB: ____/____/____
 Grade _____ Sport _____
 Date form completed ____/____/____

Health History To Be Completed By Parent/Guardian

Answer questions below to indicate if your child has or has ever had the following and provide details to any yes answer on back:

Question	YES	NO
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?		
Does s/he worry about their weight?		
Question	YES	NO
Does s/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?		
Females Only	YES	NO
Has she had her period? At what age did it begin?		
How often does she get her period?		
Date of last menstrual period		
Males Only	YES	NO
Does he have only one testicle?		
Family History	YES	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?		
Has any relative died suddenly before the age of 50 from unknown or heart related cause?		

PLEASE PROVIDE DETAILS FOR ANY YES ANSWERS ON THE BACK AND SIGN (PARENT SIGNATURE REQUIRED)