

**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

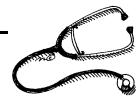
**PART B: TO BE COMPLETED BY THE PARENT OR GUARDIAN**

**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