

INTERVAL HEALTH HISTORY FOR SPORTS PARTICIPATION

Circle: Fall Winter Spring

Year: _____ _____ _____

(eg: 2018)

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 STUDENT

Student: _____ Gender: _____ Date of Birth: ____/____/____

Grade (check): 7 8 9 10 11 12 School: KHS MCM JWB COLEMAN

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

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 (ie. 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/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	<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

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".

PART D: PARENTAL PERMISSION

I, the undersigned, clearly understand these questions are asked to decide if my child can safely participate on the athletic team named in PART A of this form. As of this date, all answers are correct and he/she has my permission to participate.

SIGNED: _____ DATE: ____/____/____

Weekday Phone Number: _____

PART E - TO BE COMPLETED BY THE SCHOOL NURSE

Date of last sport physical: _____

Approved

Not Approved

Reason:

Medication Order needed / clarification needed

Clearance needed from FMD / ortho / other _____

Other: _____

School doctor to review

Signed _____ RN Date _____