INTERVAL HEALTH HISTORY FOR SPORTS PARTICIPATION

PART A:
Student: __________________ _ Age: ____ _
Grade (check): □ 7 □ 8 □ 9 □ 10 □ 11 □ 12 Date of Birth: ___ / ___ / ___
Sport: __________________ Level (check): □ Varsity □ JV □ Modified
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.) □ Yes □ No
Does the student carry an Epi-pen for a life-threatening allergy?
Asthma □ Yes □ No
Does the student carry an inhaler?
Concussion/Head injury/Seizures □ Yes □ No
Recent injury that requires medical attention or protective equipment?
Recent illness lasting longer than one week (ie. Mono) □ Yes □ No
Currently taking medications □ Yes □ No
Diabetes/Hypoglycemia □ Yes □ No
Heart/Blood Pressure Problems □ Yes □ No
Heat Exhaustion or Stroke □ Yes □ No
Hearing Impairment □ Yes □ No
Bleeding Tendency/Anemia □ Yes □ No
Recent Surgery or Hospitalization □ Yes □ No
Kidney/Liver Disease □ Yes □ No
Contact Lenses □ Yes □ No
Is there any medical condition that might be aggravated by playing sports?

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 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
940 North Rd
Scottville NY 14546
Fax 889-6217

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