Wheatland Chili School Health Services

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?	❑ Yes	❑ No
Asthma	❑ Yes	❑ No
Does the student carry an inhaler?	❑ Yes	❑ No
Concussion/Head injury/Seizures	❑ Yes	❑ No
Recent injury that requires medical attention or protective equipment?	❑ Yes	❑ No
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?	❑ Yes	❑ 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 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