

Schalmont Central School District Interval Health History Form for Sports Participation

Prior to the start of tryout sessions or practice at the beginning of each season, a health history review for each student **must** be completed.

Part A TO BE COMPLETED BY THE STUDENT

Student Name _____ DOB _____
 Grade _____ Age _____ Grade level (check one) ___ Var ___ JV ___ Frosh ___ Jr. High
 Sport _____

Part B TO BE COMPLETED BY THE PARENT OR GUARDIAN

NOTE: "Yes" to any of these questions does not mean automatic disqualification from participation in sports. However, it will require a review and approval by the school physician before the student can report to practice or tryouts.

HISTORY SINCE LAST HEALTH APPRAISAL

If the answer to any of the following questions is "YES", please describe the condition or situation that prompted your answer, giving the date and doctor clearance in Part C.

****NOTE: Injuries within the last year only.**

- | | | | | |
|-----|---|-----|----|------------|
| 1. | Any injuries requiring medical attention including concussion or loss of consciousness? | YES | NO | DATE _____ |
| 2. | Any illness lasting more than 5 days? | YES | NO | DATE _____ |
| 3. | Currently taking medication or under the care of a physician? | YES | NO | DATE _____ |
| 4. | Any feelings of faintness, dizziness, fatigue, or chest pain after exercise or exertion? | YES | NO | DATE _____ |
| 5. | Change in wearing glasses or contact lenses? | YES | NO | DATE _____ |
| 6. | Any fractures or surgical procedures? | YES | NO | DATE _____ |
| 7. | Any treatment in a hospital or emergency room? | YES | NO | DATE _____ |
| 8. | Developed any allergies, asthma, exercise induced asthma or reactions to medication? | YES | NO | DATE _____ |
| 9. | Any chronic disease? (Diabetes, bleeding disorder, seizures) | YES | NO | DATE _____ |
| 10. | Problems with heat exhaustion/heat fatigue? | YES | NO | DATE _____ |
| 11. | Absence of or the significant impairment of one of a pair of organs? (kidney, eye, ear, testicle) | YES | NO | DATE _____ |
| 12. | Any history of sudden death in a family member under the age of 50? | YES | NO | DATE _____ |

PART C - TO BE COMPLETED BY PARENT OR GUARDIAN

Describe the condition or situation that caused you to answer "YES" to any question in PART B.

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 _____

Student Name _____

TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE:

Sports Participation (check)

___ Approved _____ Referred to School Physician

Signed _____ Date ____/____/____
 School Health Office

If referred to the School Physician (check):

___ Requalified _____ Disqualified

Signed _____ Date ____/____/____
 School Physician

PLEASE RETURN TO THE HEALTH OFFICE