

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): 7 8 9 10 11 12 Date of Birth: ____ / ____ / ____
Sport: _____ Level (check): Varsity JV Frosh 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 will require a review and approval by the school physician before the student can report to practice or tryouts. The answers to the questions on this form will be held in the school health office, and will be kept confidential.

HISTORY SINCE LAST HEALTH APPRAISAL:

If the answer to any of the following questions is “YES”, in PART C on the reverse side of this form, please describe the condition or situation that prompted your answer.

- 1. Any injuries requiring medical attention? Yes No
- 2. Any illness lasting more than five (5) days? Yes No
- 3. Taking medicine or under physician’s care at this time? Yes No
- 4. Any feeling of faintness, dizziness or fatigue after exercise or exertion? Yes No
- 5. Change in wearing glasses or contact lenses? Yes No
- 6. Any surgical operations or fractures? Yes No
- 7. Any treatment in a hospital or emergency room? Yes No
- 8. Developed any allergies? Yes No
- 9. Any chronic disease? 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

PART E: TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE

Sports Participation:

- Approved Referred to School Clinician

Signed: _____ Date: ____/____/____
 School Health Office

If referred to the School Clinician:

- Requalified Disqualified

Signed: _____ Date: ____/____/____
 School Clinician