INTERVAL HEALTH HISTORY FOR SPORTS PARTICIPATION

Prior to the start of each sports season (fall, winter, spring and including the try-out period), New York State Education Law requires a health history review for those students (grades 7 to 12) who plan to participate in team sports unless the student received a full medical examination within 30 days of the season. This review covers only the time since the student’s most current physical exam dated within the past 12 months and on file in the school.

Student ___________________________ Date of birth ________________________

Grade _____ Sport ____________ Level (circle) Varsity  Junior Varsity  Middle School

Date of last full physical exam ________ Limitations: Yes __ No ___ If “yes” please explain:

________________________________________________________________________

________________________________________________________________________

Height _____ Weight _____ Allergies ____________________________

Please circle yes or no to the following:

Since the last physical
* have there been any injuries? Yes No  * illness lasting more than 5 days? Yes No
* dizziness or fatigue on exertion? Yes No  * history of concussion? Yes No
* surgeries or fractures? Yes No  * history of asthma? Yes No
* any emergency room visits? Yes No  * any change in diet? Yes No
* change in exercise program? Yes No  * does your child wear contact lenses? Yes No
* does your child wear glasses? Yes No  * take medication? Yes No
* Is your child presently under medical care? Yes No

If you answered yes to any of the above questions, please explain:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Parent’s name (print) __________________________ Signature __________________________ Date ________

________________________________________________________________________

Sports participation: approved _____ referred to medical care provider for evaluation ________

School nurse’s signature __________________________

revised 5/12