# 2022-2023 INTERVAL HEALTH HISTORY FORM FOR ATHLETICS

**NOTE: This form is required to be completed each Season. This must be signed 10 days or less before practice/tryouts begin.**

| Student Name: | | DOB: Age: |
|---|---|---|
| Grade (check): ☐6☐7 ☐8 ☐9 ☐10 ☐11 ☐12 | Level (check): ☐Modified ☐JV ☐Varsity | |
| Sport: | Limitations: ☐Yes ☐No | |
| Date of last health exam: | Date form completed: | |

**Health History To Be Completed By Parent/Guardian, Provide Details To Any Yes Answers On Page 3.**
Any medications to be taken at practice and/or athletic event will require the proper paperwork, contact school with questions.

| Has/Does your child: | | |
|---|---|---|
| **General Health Concerns** | **Yes** | **No** |
| Ever been restricted by a doctor, physician assistant, or nurse practitioner from sports participation for any reason? | | |
| Have an ongoing medical condition?<br>☐ Asthma ☐ Diabetes ☐ Seizures ☐ Sickle Cell trait or disease ☐ Scoliosis ☐ Other | | |
| Ever had surgery? | | |
| Ever spent the night in a hospital? | | |
| Been diagnosed with Mononucleosis within the last month? | | |
| Have only one functioning kidney? | | |
| Have a bleeding disorder? | | |
| Have any problems with his/her hearing or wears hearing aid(s)? | | |
| Have any problems with his/her vision or has vision in only one eye? | | |
| Wear glasses or contacts? | | |
| Has he/she ever fainted? | | |
| Has he/she ever had Rheumatic fever? | | |
| Is he/she currently taking any medications? | | |
| **Allergies** | **Yes** | **No** |
| Have a life threatening allergy? Check all that apply:<br>☐ Food ☐ Insect Bite ☐ Latex ☐ Medicine ☐ Pollen ☐ Anaphylaxis ☐ Other | | |
| Carry an epinephrine auto-injector? | | |
| **Breathing (Respiratory) Health** | **Yes** | **No** |
| Ever complained of getting extremely tired or short of breath during exercise? | | |
| Wheeze or cough frequently during or after exercise? | | |
| Ever been told by their health care provider they have asthma or exercise-induced asthma? | | |
| Use or carry an inhaler or nebulizer? | | |

| Has/Does your child: | | |
|---|---|---|
| **Concussion/Head/Brain Injury History** | **Yes** | **No** |
| Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told he/she had a concussion? | | |
| Ever had migraines? | | |
| Ever had headaches with exercise? | | |
| Ever had any unexplained seizures? | | |
| Receive treatment for a seizure disorder or epilepsy? | | |
| **Devices/Accommodations** | **Yes** | **No** |
| Use a brace, orthotic, or other device? | | |
| Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)? If yes there may be a need for another required form to be filled out. | | |
| Wear protective eyewear, such as goggles or a face shield? | | |
| Wear a hearing aid or cochlear implant? | | |
| **Females Only** | **Yes** | **No** |
| Have regular periods? | | |
| **Males Only** | **Yes** | **No** |
| Have only one testicle? | | |
| Have groin pain or a bulge or hernia in the groin? | | |
| **Heart Health** | **Yes** | **No** |
| Ever passed out during or after exercise? | | |
| Ever complained of light headedness or dizziness during or after exercise? | | |
| Ever complained of chest pain, tightness or pressure during or after exercise? | | |
| Ever complained of fluttering in their chest, skipped beats, or their heart racing, or does he/she have a pacemaker? | | |
| Ever had a test by their medical provider for his/her heart (e.g. EKG, echocardiogram stress test)? | | |
| Ever been told they have or had a heart condition or blood vessel problem by a physician? If so, check all that apply:<br>☐Chest Tightness or Pain ☐Heart infection ☐Heart Murmur ☐High Blood Pressure ☐Low Blood Pressure ☐High Cholesterol ☐Kawasaki Disease ☐New fast or slow heart rate ☐Has an implanted cardiac defibrillator (ICD) ☐Has a pacemaker ☐Other: | | |
| **Family Heart Health History** | **Yes** | **No** |
| Have any relative who has/had any of the following: Check all that apply<br>☐Enlarged Heart/Hypertrophic Cardiomyopathy/Dilated Cardiomyopathy<br>☐Arrhythmogenic Right Ventricular Cardiomyopathy<br>☐Heart rhythm problems, long or short QT interval<br>☐Brugada Syndrome<br>☐Catecholaminergic Ventricular Tachycardia<br>☐Marfan Syndrome (aortic rupture)<br>☐Heart attack at age 50 or younger<br>☐Pacemaker or implanted cardiac defibrillator (ICD)<br>A family history of:<br>☐Known heart abnormalities or sudden death before the age of 50?<br>☐Structural heart abnormality repaired or unrepaired?<br>☐ Unexplained fainting, seizures, drowning, near drowning, or car accident before age 50? | | |
| **Injury History** | **Yes** | **No** |
| Ever been diagnosed with a stress fracture? | | |
| Ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling? | | |
| Ever had an injury, pain, or swelling of joint that caused him/her to miss practice or a game? | | |
| Have a bone, muscle, or joint injury that bothers him/her? | | |

| Have joints become painful, swollen, warm, or red with use? | | |
|---|---|---|

| **Has/Does your child:** | | |
|---|---|---|
| **Skin Health** | **Yes** | **No** |
| Currently have any rashes, pressure sores, or other skin problems? | | |
| Have had a herpes or MRSA skin infection? | | |
| **Digestive (GI) Health** | **Yes** | **No** |
| Ever become ill while exercising in hot weather? | | |
| Have a special diet or have to avoid certain foods? | | |
| Have concerns about his/her weight? | | |
| Have stomach or other GI problems? | | |
| Ever had an eating disorder? | | |
| **COVID-19 Information** | | |
| Has your child ever tested positive for COVID-19? | | |
| Date (s) of positive COVID test: | | |
| Was your child symptomatic? | | |
| Did your child see a health care provider for their COVID-19 symptoms? | | |
| Was your child hospitalized? If yes, provide dates : | | |
| Was your child diagnosed with Multisystem Inflammatory Syndrome (MISC)?<br>If yes, is your child under a health care provider's care for this? | | |

**If you answered NO to ALL questions please sign here**

**Parent/Guardian Signature:____________________________________ Date: ____________________**

**If you answered YES to any questions please explain fully in the space below.** (Please print clearly and provide dates if known.)

**Parent/Guardian Signature:____________________________________ Date: ____________________**

I hereby state that my child has had no serious illness or history of serious illness other than noted above, which has come to my knowledge through either physician or practitioner who has treated him/her in the past. To the best of my knowledge he/she does not have a serious condition which might prevent his/her safe participation in school athletic activities.

____________________________________________ ________________________

**SIGNATURE OF PARENT/GUARDIAN** **DATE** **Revised 7.22**