COMPLETE 30 DAYS OR LESS BEFORE SEASON/PRACTICE BEGINS

Interval Health History for Athletics

Student Name:	DOB:
School Name:	Age:
Grade (check): ☐7 ☐8 ☐9 ☐10 ☐11 ☐12	Limitations: ☐ NO ☐ YES
Sport:	Date of last Health Exam:
Sport Level: ☐Modified ☐ Fresh ☐ JV ☐ Varsity	Date form completed:

MUST be completed and signed by Parent/Guardian - Give details to any YES answers on the last page.

SINCE YOUR CHILD'S LAST HEALTH EXAM – HAS YOUR CHILD?

GENERAL HEALTH	NO	YES
Been restricted by a health care provider from sports participation for any reason?	☐	☐
Had surgery?	☐	☐
Spent the night in a hospital?	☐	☐
Been diagnosed with mononucleosis within the last month?	☐	☐
Has only one functioning kidney?	☐	☐
Has or had a bleeding disorder?	☐	☐
Having problems with hearing or have congenital deafness?	☐	☐
Having problems with vision or only have vision in one eye?	☐	☐
Been diagnosed with a new medical condition?	☐	☐
If yes, check all that apply: ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Sickle cell trait or disease ☐ Other:		
Developed Allergies?	☐	☐
If yes, check all that apply ☐ Food ☐ Insect Bite ☐ Latex ☐ Medicine ☐ Other: ☐ Pollen		
Had anaphylaxis?	☐	☐
Carry an epinephrine auto-injector?	☐	☐
Had or has groin pain, a bulge, or a hernia?	☐	☐
DEVICES / ACCOMMODATIONS	**NO**	**YES**
Uses a brace, orthotic, or another device?	☐	☐
Has special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)?	☐	☐
Wears protective eyewear, such as goggles or a face shield?	☐	☐
Wears a hearing aid or cochlear implant?	☐	☐

Let the coach/school nurse know of any device used. Not required for contact lenses or eyeglasses.

SINCE YOUR CHILD'S LAST HEALTH EXAM – HAS YOUR CHILD?

BRAIN/HEAD INJURY HISTORY	NO	YES
Has or had a hit to the head that caused headache, dizziness, nausea, or confusion, or been told they had a concussion?	☐	☐
Received treatment for a seizure disorder or epilepsy?	☐	☐
Has or had headaches with exercise?	☐	☐
Has or had migraines?	☐	☐
BREATHING	**NO**	**YES**
Complained of getting extremely tired or short of breath during exercise?	☐	☐
Used or carries an inhaler or nebulizer?	☐	☐
Has or had wheezing or coughing frequently during or after exercise?	☐	☐
Been told by a health care provider they have asthma or exercise-induced asthma?	☐	☐
DIGESTIVE (GI) HEALTH	**NO**	**YES**
Has or had stomach or other GI problems?	☐	☐
Has an eating disorder?	☐	☐
Has a special diet or need to avoid certain foods?	☐	☐
Do you have concerns about your child's weight?	☐	☐
INJURY HISTORY	**NO**	**YES**
Been unable to move their arms or legs or had tingling, numbness, or weakness after being hit or falling?	☐	☐
Had an injury, pain, or joint swelling caused them to miss practice or a game?	☐	☐
Has or had a bone, muscle, or joint that bothers them?	☐	☐
Has or had joints that become painful, swollen, warm, or red with use?	☐	☐
Been diagnosed with a stress fracture?	☐	☐
FEMALES ONLY	**NO**	**YES**
Change in period frequency related to female athlete triad?	☐	☐

Student Name:	DOB:

SINCE YOUR CHILD'S LAST HEALTH EXAM – HAS YOUR CHILD?		
MALES ONLY	**NO**	**YES**
Has only one testicle?	☐	☐
SKIN HEALTH	**NO**	**YES**
Has any rashes, pressure sores, or other skin problems?	☐	☐
Has a herpes or MRSA skin infection?	☐	☐
COVID-19 INFORMATION	**NO**	**YES**
Child tested positive for COVID-19?	☐	☐
IF NO, STOP and go to Family Heart Health History. If **YES,** answer the questions below:		
Date of positive COVID test:		
Was your child symptomatic?	☐	☐
Did your child see a healthcare provider for their COVID-19 symptoms?	☐	☐
Was your child hospitalized for COVID?	☐	☐
Was your child diagnosed with Multisystem Inflammatory Syndrome (MISC)?	☐	☐

SINCE YOUR CHILD'S LAST HEALTH EXAM – HAS YOUR CHILD?		
HEART HEALTH	**NO**	**YES**
Had a test by a health care provider for their heart (e.g., EKG, echocardiogram, stress test)?	☐	☐
Has or had lightheadedness or dizziness during or after exercise?	☐	☐
Has or had chest pain, tightness, or pressure during or after exercise?	☐	☐
Has or had fluttering in the chest, skipped heartbeats, heart racing?	☐	☐
Been told by a healthcare provider they have or had a heart or blood vessel problem?	☐	☐

If yes, check all that apply:

- ☐ Chest Tightness or Pain
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ New fast or slow heart rate
- ☐ Heart Infections
- ☐ Heart Murmur
- ☐ High Cholesterol
- ☐ Kawasaki Disease
- ☐ Has implanted cardiac defibrillator (ICD)
- ☐ Had a pacemaker implanted
- ☐ Other:

SINCE YOUR CHILD'S LAST HEALTH EXAM - CHECK ANY **NEW** FAMILY HEART HEALTH HISTORY

A relative had or is currently experiencing any of the following: (Check all that apply)

- ☐ Enlarged Heart/ Hypertrophic Cardiomyopathy/ Dilated Cardiomyopathy
- ☐ Arrhythmogenic Right Ventricular Cardiomyopathy?
- ☐ Heart rhythm problems: long or short QT interval?
- ☐ Structural heart abnormality, repaired or unrepaired?
- ☐ Brugada Syndrome?
- ☐ Catecholaminergic Ventricular Tachycardia?
- ☐ Marfan Syndrome (aortic rupture)?
- ☐ Heart attack at age 50 or younger?
- ☐ Pacemaker or implanted cardiac defibrillator (ICD)?
- ☐ Known heart abnormalities or sudden death before age 50?
- ☐ Unexplained fainting, seizures, drowning, near drowning, or car accident before age 50?

If you answered **NO** to ***all*** questions, **STOP**. Sign and date below.
GO to page 3 if you answered **YES** to a question.

☐ Information on this form is NEW information since my child's last health examination.

Parent/Guardian Signature:	Date:

Student Name:	DOB:

If you answered YES to any questions, give details. Sign and date below.

Parent/Guardian Signature:	Date: