# Interval Health History for Athletics

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|---|---|
| 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:<br>☐ Asthma ☐ Diabetes<br>☐ Seizures ☐ Sickle cell trait or disease<br>☐ Other: | | |
| Developed Allergies? | ☐ | ☐ |
| If yes, check all that apply<br>☐ Food ☐ Insect Bite ☐ Latex<br>☐ Medicine ☐ Other:<br>☐ 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? | ☐ | ☐ |
| **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 and continue to page 3 for liability waiver.

☐ 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. |
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| Parent/Guardian Signature: | Date: |
|---|---|

Participation in sports involves a certain degree of risk for injury. Such physical injury can occur in any type of sports activity and vary in nature. Athletic injuries can vary from minor injuries such as bruises and scrapes to more serious injuries such as fractures, dislocations, concussions, paralysis and even fatalities.

I have carefully read and understand the health history questions. To the best of my knowledge there is no existing condition that should exclude my son/daughter from athletic participation.

I have also received and reviewed the information on concussions and management.

My signature below constitutes my permission for my child to participate in the above named sport.

I understand the district does not assume responsibility for lost or broken corrective lenses or orthodontic devices.

In the event of an emergency, my signature below constitutes my permission for my child to receive medical evaluation and necessary treatment to ensure his/her health and safety. Such treatment may come from either my child's physician or another physician or medical facility as deemed appropriate by the supervising ECS staff member at his/her discretion. I appoint that ECS staff member as my Attorney in Fact to execute any necessary documents in connection with the medical treatment including any required guarantee of payment. I hereby agree to accept responsibility for medical, hospital or physician's bills not covered by an insurance plan I may have, or the secondary policy of Ellicottville Central School which is provided by ECS's Board of Education. I understand that my own insurance plan, if any, MUST be used before the Ellicottville plan. Ellicottville Central Schools Accidental Insurance Plan, is primary to Tri-Care, Medicaid and Child Health Plus.

Parent/Guardian Signature: _____

Date: _____