INTERVAL HEALTH HISTORY FOR SPORTS PARTICIPATION AT SCHENEVUS CENTRAL SCHOOL

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.

Student:_____DOB:_____ Sex M/F

Grade (check): • 7 •8 • 9 • 10 • 11 • 12 Sport:_____

Date of last health appraisal: _____/_____/_____ Limitations: • Yes • No

Note: A "Yes" to any of these questions does not mean automatic disqualification from the athletic activity. However, it will require a review and approval by the school nurse and or 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", please describe the condition or situation that prompted your answer.

1. Any injuries requiring medical attention? • Yes • No
   (Diabetes/Hypertension/Concession/Seizures/Bleeding tendencies etc.)
2. Any illness lasting more than five (5) days? • Yes • No
   (ie:Mono)
3. Taking medicine or under physician's care at this time? • Yes • No
   (Asthma: Inhalers, Allergies: epi-pen)
4. Any feeling of faintness, dizziness or fatigue after exercise or exertion? • Yes • No
5. Wear 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. Allergies? (Bee Sting/Medication/Food/Latex) • Yes • No
   (Carry an Epi-pen for life threatening allergy?)
9. Any chronic disease? • Yes • No

Describe the condition or situation that caused any questions in to be answered "YES".

_____

_____

_____

(see back for more information)

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. 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

TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE

Sports Participation: • Approved • Referred to School Physician

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

If referred to the School Physician:

- Requalified
- Disqualified

Signed:_____ Date:_____/_____/_____
School Physician