HOOSIC VALLEY CENTRAL SCHOOL DISTRICT

INTERVAL HEALTH HISTORY FOR SPORTS PARTICIPATION

Prior to the start of tryout sessions or practices, 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:_____ Age:_____

Grade: _____ Date of Birth: ____ /____ /____

Sport: _____ Limitations: ❑ Yes ❑ No

Date of last health appraisal: _____/_____/_____

PART A: TO BE COMPLETED BY THE PARENT OR GUARDIAN

Note: *"Yes" to any of these questions does not mean automatic disqualification from the athletic activity, however, it may require a review and approval by the school physician before the student can report to practice or tryouts.*

HISTORY SINCE LAST HEALTH APPRAISAL:

Allergies (Bee Sting/Medications/Food/Latex,etc.)	❑ Yes ❑ No
Does the student carry an Epi-pen® for a life-threatening allergy?	❑ Yes ❑ No
Asthma	❑ Yes ❑ No
Does the student carry an inhaler?	❑ Yes ❑ No
Concussion/Head injury/Seizures	❑ Yes ❑ No
Recent injury that requires medical attention or protective equipment?	❑ Yes ❑ No
Recent illness lasting longer than one week (ie. Mono)	❑ Yes ❑ No
Currently taking medications	❑ Yes ❑ No
Diabetes/Hypoglycemia	❑ Yes ❑ No
Heart/Blood Pressure Problems	❑ Yes ❑ No
Heat Exhaustion or Stroke	❑ Yes ❑ No
Hearing Impairment	❑ Yes ❑ No
Bleeding Tendency/Anemia	❑ Yes ❑ No
Recent Surgery or Hospitalization	❑ Yes ❑ No
Kidney/Liver Disease	❑ Yes ❑ No
Contact Lenses	❑ Yes ❑ No
Is there any medical condition that might be aggravated by playing sports?	❑ Yes ❑ No

PART B: TO BE COMPLETED BY PARENT OR GUARDIAN

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

_____
_____
_____
_____
_____
_____

PART C: PARENTAL PERMISSION

I, the undersigned, clearly understand these questions are asked in order to decide if my child can safely participate on an 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

PART D: 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