



**HEALTH HISTORY
INTERVAL UPDATE**

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.

PART A - TO BE COMPLETED BY STUDENT

Student: _____ Age: _____

Grade (check): 7 8 9 10 11 12

Sport: _____ Level (check): Var JV Fresh Modified

PART B - TO BE COMPLETED BY THE PARENT OR GUARDIAN

NOTE: "YES" to any of these questions does not mean automatic disqualification from the athletic activity indicated in PART A above. However, it will require a review and approval by the 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 in PART C on the reverse side of this form.

	(CHECK)	
	YES	NO
1. Any injuries requiring medical attention?	<input type="checkbox"/>	<input type="checkbox"/>
2. Any illness lasting more than five (5) days?	<input type="checkbox"/>	<input type="checkbox"/>
3. Taking any medicine or under physician's care at this time?	<input type="checkbox"/>	<input type="checkbox"/>
4. Any feeling of faintness, dizziness or fatigue after exercise or exertion?	<input type="checkbox"/>	<input type="checkbox"/>
5. Change in wearing glasses or contacts?	<input type="checkbox"/>	<input type="checkbox"/>
6. Any surgical operations or fractures?	<input type="checkbox"/>	<input type="checkbox"/>
7. Any treatment in a hospital or emergency room?	<input type="checkbox"/>	<input type="checkbox"/>
8. Developed any allergies?	<input type="checkbox"/>	<input type="checkbox"/>
9. Any chronic disease?	<input type="checkbox"/>	<input type="checkbox"/>

PART C - TO BE COMPLETED BY PARENT OR GUARDIAN

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

PART D - MEDICATIONS (Please complete if your child will need to take medication while at practices and/or games.

What medication will your child need to have available for her/him to take while at games and/or practices?

Name of Medication: _____ Dosage: _____
For what reason? _____

As per New York State law and for the protection of your child, we will need to have a physician's written permission filed in the health office as well as a written permission from the parent/guardian before your child will be permitted to take medication during all school related activities. Please contact the health office for further information and forms to be completed.

PART E - 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 named in PART A of this form. The answers are correct as of this date and he/she has my permission to participate.

I also agree to emergency medical treatment as deemed necessary by the physicians designated by school authorities.

SIGNED: _____ **DATE:** ___/___/___

PART F - TO BE COMPLETED BY THE SCHOOL HEALTH OFFICER

Date of last health appraisal: ___/___/___ Limitations: Yes No

Sports Participation (check): _____ Approved _____ Referred to School Physician

If referred to School Physician (check): _____ Requalified _____ Disqualified

Signed _____ Date: ___/___/___
School Physician