

INTERVAL HEALTH HISTORY

Prior to the start of tryout sessions or practice at the beginning of each season, an interval health history review for each athlete must be conducted unless the student received a full medical examination within thirty (30) days of the start of the season.

Part A.

Date: _____

Student: _____

Age: _____

Grade: _____

D.O.B. _____

Sport: _____

Level: Var JV Frosh Jr. High

Date of Last Health Exam: _____ Last Tetanus: _____

Limitations: yes no

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 is "YES" to any of the following questions in Part C on the reverse side of this form, please describe the condition or situation that prompted your answer.

1. Any injuries requiring medical attention? YES ____ NO ____
2. Any illness lasting more than five (5) days? YES ____ NO ____
3. Taking medicine or under physician's care at this time? YES ____ NO ____
4. Any feeling of faintness, dizziness or fatigue after exercise or exertion? YES ____ NO ____
5. Change in wearing 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. Develop any allergies? YES ____ NO ____
9. Any chronic disease? (asthma, diabetes, heart murmur, etc.) YES ____ NO ____

Part C. To be completed by parent or guardian

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

Part D. 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.

Signed _____

Date _____

PLEASE RETURN TO THE SCHOOL HEALTH OFFICE

Part E. To be completed by the school health office

Sports Participation:

Approved

Referred to school physician

Signed: _____
(School health office)

Date: _____

If referred to the school physician:

Qualified

Disqualified

Signed: _____
School Physician

Date: _____