

SEWANHAKA CENTRAL HIGH SCHOOL DISTRICT
PRE-PARTICIPATION EVALUATION/INTERVAL FORM

Please Print)

Student Name: _____ Grade: _____ School: _____
Last Name First Name

Address: _____

Date of Last Physical Examination: _____ Sport & Level: _____ Season _____

The student must be examined and approved for interscholastic sports at least once each school year. However, the student must be re-examined and re-certified by the **School Physician** and/or school nurse before returning to practice or competition in the event of any of the following circumstances:

Please answer the following questions:

- | | | |
|--|-----|----|
| 1. Has your child had any health changes since your last physical examination? | YES | NO |
| 2. Has your child had an injury requiring doctor's care since your last examination? | YES | NO |
| 3. Has your child had any head injury or sustained a concussion since your last examination? | YES | NO |
| 4. Has your child have been hospitalized for any reason since your last examination? | YES | NO |
| 5. Do you have an ongoing medical condition? | | |
| <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Seizures <input type="checkbox"/> Sickle Cell Trait/Disease <input type="checkbox"/> Cardiac <input type="checkbox"/> Other | | |

COVID-19 Information:

- | | | |
|--|-----|----|
| 6. Has your child tested positive for COVID-19 since the last physical examination? | YES | NO |
| 7. Was your child symptomatic? | YES | NO |
| 8. Did your child see a healthcare provider for their COVID-19 symptoms? | YES | NO |
| 9. Did your child have any cardiac symptoms? (fast or slow heart rate, chest pain or tightness, blood pressure changes, or a diagnosed cardiac condition) If YES, please provide additional information. | YES | NO |
| 10. Was your child hospitalized? If yes, provide date(s)? _____ | YES | NO |
| a. If yes, was your child diagnosed with Multisystem Inflammatory Syndrome (MISC)? | YES | NO |
| b. If yes, is your child under a physician's care for this? | YES | NO |

*** Heart Health:**

- | | | |
|--|-----|----|
| 11. Has your child had a test by a DR. for their heart (e.g., EKG, Echocardiogram, Stress Test)? | YES | NO |
| 12. Has your child ever complained of lightheadedness or dizziness during or after exercise? | YES | NO |
| 13. Has your child ever complained of chest pain, tightness, or pressure during or after exercise? | YES | NO |
| 14. Has your child ever complained of skipped heartbeats, fluttering or heart racing? | YES | NO |
| 15. Has your child been evaluated by a health care provider for a heart condition or blood vessel problem? | YES | NO |

If yes, check all that apply:

- High Blood Pressure Low Blood Pressure High Cholesterol New Fast or Slow Heart Rate Pacemaker
 Implanted Cardiac Defibrillator Heart Murmur Heart Infection Kawasaki Disease Chest Tightness or Pain Other

*** Family Heart Health:**

16. A relative has or had 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 Brugada Syndrome Catecholaminergic Ventricular Tachycardia
 Marfan Syndrome (Aortic Rupture) Pacemaker or Implanted Cardiac Defibrillator Heart Attack at Age 50 or Younger
17. A family history of: (Check all that apply)
- Known Heart Abnormalities or Sudden Death Before Age 50 Structural Heart Abnormality, Repaired or Unrepaired
 Unexplained Fainting, Seizures, Drowning, Near Drowning, or Car Accident Before Age 50

If you answered YES to any questions, you must present a note from your child's physician indicating that your child can participate. Any athlete whose safe participation is in question after review of this Pre-Participation Evaluation/Interval Form, due to a new injury or prolonged absence must be re-qualified by the school physician and/or school nurse. If you answered YES to any questions, please explain below, and include dates. Use additional pages if necessary.

Student Signature

Signature of Parent or Guardian

Date

School Nurse Signature

Parent Cell Number

* Questions required by the new Dominic Murray Sudden Cardiac Arrest Prevention Act – Eff. July 1, 2022

7/27/22

For more information, visit: [NYSED Health Services webpage](#)