

INTERVAL HEALTH HISTORY FOR SPORTS PARTICIPATION

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.

PART A: TO BE COMPLETED BY THE PARENT OR GUARDIAN

Student: \_\_\_\_\_

Age: \_\_\_\_\_

Grade (check):  7  8  9  10  11  12

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Sport: \_\_\_\_\_

Level (check):  Varsity  JV  Modified

Note: "Yes" to any of these questions does not mean automatic disqualification from the athletic activity indicated in PART A above. 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:

- 1. Allergies (Bee Sting/Medications/Food/Latex,etc.)  Yes  No
Does the student carry an Epi-pen® for a life-threatening allergy?  Yes  No
2. Any illness lasting longer than two weeks (ie. Mono)  Yes  No
3. Currently taking any new daily medications  Yes  No
4. Any injuries requiring medical attention  Yes  No
(ie. Head injury/concussion, fractures, surgeries, long-term illness)

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".

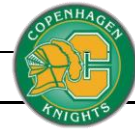
Empty rectangular box for describing conditions.

PART C: 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 HEALTH OFFICE



**PART D: TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE**

Date of last health appraisal: \_\_\_\_/\_\_\_\_/\_\_\_\_

Limitations:  Yes  No


Sports Participation:

- Approved                       Referred to School Physician

Signed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
School Health Office

If referred to the School Physician:

- Requalified                       Disqualified

Signed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
School Physician