

Spencer Van Etten Interval Health History for Athletics

Student Name:		DOB
School Name:		Age
Grade (check): <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12		Limitations: <input type="checkbox"/> NO <input type="checkbox"/> YES
Sport		Date of last Health Exam:
Sport Level: <input type="checkbox"/> Modified <input type="checkbox"/> Fresh <input type="checkbox"/> JV <input type="checkbox"/> Varsity		Date form completed:
MUST be completed and signed by Parent/Guardian - Give details to any YES answers on the last page.		

DOES OR HAS YOUR CHILD		
GENERAL HEALTH	NO	YES
Ever been restricted by a health care provider from sports participation for any reason?		
Ever had surgery?		
Ever spent the night in a hospital?		
Been diagnosed with mononucleosis within the last month?		
Have only one functioning kidney?		
Have a bleeding disorder?		
Have any problems with hearing or have congenital deafness?		
Have any problems with vision or only have vision in one eye?		
Have an ongoing medical condition?		
If yes, check all that apply:		
<input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Seizures <input type="checkbox"/> Sickle cell trait or disease <input type="checkbox"/> Other:		
Have Allergies?		
If yes, check all that apply		
<input type="checkbox"/> Food <input type="checkbox"/> Insect Bite <input type="checkbox"/> Latex <input type="checkbox"/> Medicine <input type="checkbox"/> Pollen <input type="checkbox"/> Other:		
Ever had anaphylaxis?		
Carry an epinephrine auto-injector?		
BRAIN/HEAD INJURY HISTORY	NO	YES
Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told they had a concussion?		
Receive treatment for a seizure disorder or epilepsy?		
Ever had headaches with exercise?		
Ever had migraines?		

DOES OR HAS YOUR CHILD		
BREATHING	NO	YES
Ever complained of getting extremely tired or short of breath during exercise?		
Use or carry an inhaler or nebulizer?		
Wheeze or cough frequently during or after exercise?		
Ever been told by a health care provider they have asthma or exercise-induced asthma?		
DEVICES / ACCOMMODATIONS	NO	YES
Use a brace, orthotic, or another device?		
Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)?		
Wear protective eyewear, such as goggles or a face shield?		
Wear a hearing aid or cochlear implant?		
Let the coach/school nurse know of any device used. Not required for contact lenses or eyeglasses.		
DIGESTIVE (GI) HEALTH	NO	YES
Have stomach or other GI problems?		
Ever had an eating disorder?		
Have a special diet or need to avoid certain foods?		
Are there any concerns about your child's weight?		
INJURY HISTORY	NO	YES
Ever been unable to move their arms or legs or had tingling, numbness, or weakness after being hit or falling?		
Ever had an injury, pain, or swelling of a joint that caused them to miss practice or a game?		
Have a bone, muscle, or joint that bothers them?		
Have joints that become painful, swollen, warm, or red with use?		
Ever been diagnosed with a stress fracture?		

updated 8/2022

Student Name:		DOB:	
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DOES OR HAS YOUR CHILD		
HEART HEALTH		
Ever complained of:		
Ever had a test by a health care provider for their heart (e.g., EKG, echocardiogram, stress test)?		
Lightheadedness, dizziness, during or after exercise?		
Chest pain, tightness, or pressure during or after exercise?		
Fluttering in the chest, skipped heartbeats, heart racing?		
DOES OR HAS YOUR CHILD		
Ever been told by a health care provider		
They have or had a heart or blood vessel problem?		
If yes, check all that apply:		
<input type="checkbox"/> Chest Tightness or Pain	<input type="checkbox"/> Heart infection	
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Murmur	
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Low Blood Pressure	
<input type="checkbox"/> New fast or slow heart rate	<input type="checkbox"/> Kawasaki Disease	
<input type="checkbox"/> Has implanted cardiac defibrillator (ICD)		
<input type="checkbox"/> Has a pacemaker		
<input type="checkbox"/> Other:		

DOES OR HAS YOUR CHILD		
FEMALES ONLY	No	Yes
Have regular periods?		
MALES ONLY	No	Yes
Have only one testicle?		
Have groin pain or a bulge, or a hernia?		
SKIN HEALTH	No	Yes
Currently have any rashes, pressure sores, or other skin problems?		
Ever had a herpes or MRSA skin infection?		
COVID-19 INFORMATION		
Has your child ever tested positive for COVID-19?		
If NO, STOP. Go to Family Heart Health History. If YES, answer questions below:		
Date of positive COVID test:		
Was your child symptomatic?		
Did your child see a health care provider for their COVID-19 symptoms?		
Was your child hospitalized for COVID?		
Was your child diagnosed with Multisystem Inflammatory Syndrome (MISC)?		

FAMILY HEART HEALTH HISTORY	
A relative has/had any of the following: Check all that apply:	
<input type="checkbox"/> Enlarged Heart/ Hypertrophic Cardiomyopathy/ Dilated Cardiomyopathy	<input type="checkbox"/> Brugada Syndrome?
<input type="checkbox"/> Arrhythmogenic Right Ventricular Cardiomyopathy?	<input type="checkbox"/> Catecholaminergic Ventricular Tachycardia?
<input type="checkbox"/> Heart rhythm problems: long or short QT interval?	<input type="checkbox"/> Marfan Syndrome (aortic rupture)?
	<input type="checkbox"/> Heart attack at age 50 or younger?
	<input type="checkbox"/> Pacemaker or implanted cardiac defibrillator (ICD)?
A family history of:	
<input type="checkbox"/> Known heart abnormalities or sudden death before age 50?	<input type="checkbox"/> Structural heart abnormality, repaired or unrepaired?
<input type="checkbox"/> Unexplained fainting, seizures, drowning, near drowning, or car accident before age 50?	

If you answered NO to <u>all</u> questions, STOP. Sign and date below. GO to page 3 if you answered YES to a question.	
Parent/Guardian Signature:	Date:

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM TO BE COMPLETED BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR IF AN AREA IS NOT ASSESSED INDICATE NOT DONE					
Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).					
STUDENT INFORMATION					
Name				Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
School:				DOB:	
				Grade:	
				Exam Date:	
HEALTH HISTORY					
Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type		Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached			
Asthma <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type		<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached			
Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type		Type: <input type="checkbox"/> Medication/Treatment Order Attached		Date of last seizure: <input type="checkbox"/> Seizure Care Plan Attached	
Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type		Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached			
Risk Factors for Diabetes or Pre-Diabetes: <i>Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.</i>					
BMI _____ kg/m2					
Percentile (Weight Status Category): <input type="checkbox"/> <5 th <input type="checkbox"/> 5 th -49 th <input type="checkbox"/> 50 th -84 th <input type="checkbox"/> 85 th -94 th <input type="checkbox"/> 95 th -98 th <input type="checkbox"/> 99 th and>					
Hyperlipidemia: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not Done			Hypertension: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not Done		
PHYSICAL EXAMINATION/ASSESSMENT					
Height:		Weight:		BP:	
				Pulse:	
				Respirations:	
Laboratory Testing		Positive Negative		Date	
TB- PRN		<input type="checkbox"/>		<input type="checkbox"/>	
Sickle Cell Screen-PRN		<input type="checkbox"/>		<input type="checkbox"/>	
Lead Level Required Grades Pre- K & K				Date	
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 5 µg/dL					
<input type="checkbox"/> System Review and Abnormal Findings Listed Below					
<input type="checkbox"/> HEENT		<input type="checkbox"/> Lymph nodes		<input type="checkbox"/> Abdomen	
<input type="checkbox"/> Dental		<input type="checkbox"/> Cardiovascular		<input type="checkbox"/> Back/Spine	
<input type="checkbox"/> Neck		<input type="checkbox"/> Lungs		<input type="checkbox"/> Genitourinary	
				<input type="checkbox"/> Extremities	
				<input type="checkbox"/> Skin	
				<input type="checkbox"/> Neurological	
				<input type="checkbox"/> Speech	
				<input type="checkbox"/> Social Emotional	
				<input type="checkbox"/> Musculoskeletal	
<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:				Diagnoses/Problems (list) ICD-10 Code*	
<input type="checkbox"/> Additional Information Attached				*Required only for students with an IEP receiving Medicaid	

Name:				DOB:	
Vision & Hearing SCREENINGS - Required for PreK or K, 1, 3, 5, 7, & 11					
Vision (w/correction if prescribed)	Right	Left	Referral	Not Done	
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
Near Vision Acuity	20/	20/		<input type="checkbox"/>	
Color Perception Screening <input type="checkbox"/> Pass <input type="checkbox"/> Fail				<input type="checkbox"/>	
Notes					
Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.				Not Done	
Pure Tone Screening	Right <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Referral <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
Notes					
Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7	Negative <input type="checkbox"/>	Positive <input type="checkbox"/>	Referral <input type="checkbox"/> Yes <input type="checkbox"/> No	Not Done <input type="checkbox"/>	
RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK					
<input type="checkbox"/> Student may participate in all activities without restrictions. <input type="checkbox"/> Student is restricted from participation in: <div style="margin-left: 20px;"> <input type="checkbox"/> Contact Sports: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling. <input type="checkbox"/> Limited Contact Sports: Baseball, Fencing, Softball, and Volleyball. <input type="checkbox"/> Non-Contact Sports: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field. <input type="checkbox"/> Other Restrictions: </div>					
Developmental Stage for Athletic Placement Process <u>ONLY</u> required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level OR Grades 9-12 who wish to play at the modified interscholastic sports level. Tanner Stage: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V Age of First Menses (if applicable) : _____					
<input type="checkbox"/> Other Accommodations*: (e.g. Brace, orthotics, insulin pump, prosthetic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.					
MEDICATIONS					
<input type="checkbox"/> Order Form for Medication(s) Needed at School Attached					
IMMUNIZATIONS					
<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS					
HEALTH CARE PROVIDER					
Medical Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
Please Return This Form To Your Child's School When Completed.					