

**Wayland-Cohocton Central School
Interval Health History for Sports Participation**

Prior to the start of tryout session 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 Student _____ Date _____ Date of last physical _____

Sport _____ Season _____ Limitations? Y – N _____

Part B (To be completed by 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 a 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 physical:

If the answer to any of the following questions is "YES", in part C, please describe the condition or situation that prompted your answer.

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|---|-----|----|
| 1. Any injuries requiring medical attention? | Yes | No |
| 2. Any illness lasting more than 5 days? | Yes | No |
| 3. Taking medicine or under a doctor's care now? | Yes | No |
| 4. Any feeling of faintness, dizziness or extreme 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. Developed any allergies? | Yes | No |
| 9. Bee sting allergy? | Yes | No |
| 10. Developed any chronic diseases? (Diabetes, etc?) | Yes | No |
| 11. History of concussion? | Yes | No |

Part C (To be completed by parent or guardian)

Please explain any "Yes" answers from above _____

Part D (To be completed by parent or guardian)

I, the undersigned, clearly understood 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.

Signature of parent or guardian

Date

Please return this form to the school health office.

<p>Part E (To be completed by school health office)</p> <p>Sports participation (check): Approved _____ Referred to physician _____ Signed _____ Date _____ If referred to physician (check) Re-qualified _____ Disqualified _____ Signed _____ Date _____ (Or attach Physician Rx)</p>	<p style="text-align: center;">Notes</p>
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