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.

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

Part C (To be completed by the parent or guardian)
Please explain any "Yes" answers from above _____

_____

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.

_____ _____
Signature of parent or guardian Date

Please return this form to the school health office.

Part E (to be completed by the school health office)

Sports participation (check):

Approved_____ Referred to physician_____

Signed_____ Date_____

If referred to physician (check):

Re-qualified_____ Disqualified_____

Signed_____Date_____
(Or attach Physician Rx)

NOTES