School Health Services

INTERVAL HEALTH HISTORY FOR SPORTS PARTICIPATION

COPENHAGEN CENTRAL SCHOOL

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 SCHOOL HEALTH OFFICE

Student:_____ Age:_____

Grade (check): ❑ 7 ❑ 8 ❑ 9 ❑ 10 ❑ 11 ❑ 12 Date of Birth: ____ /____ /____

Sport: _____ Level (check): ❑ Varsity ❑ JV ❑ Frosh ❑ Jr. High

Date of last health appraisal: _____/_____/_____ Limitations: ❑ Yes ❑ No

PART B: TO BE COMPLETED BY THE 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 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 (ie. Head injury/concussion, factures, surgeries, long-term illness)	❑ Yes ❑ No

PART C: TO BE COMPLETED BY PARENT OR GUARDIAN

Describe the condition or situation that caused any questions in PART B to be answered "YES".

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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.

SIGNED: _____ DATE: _____/_____/_____

PLEASE RETURN TO THE SCHOOL HEALTH OFFICE

PART E: TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE

Sports Participation:

❑ Approved ❑ Referred to School Physician

Signed:_____ Date:_____/_____/_____
School Health Office

If referred to the School Physician:

❑ Requalified ❑ Disqualified

Signed:_____ Date:_____/_____/_____
School Physician