PREPARTICIPATION/INTERVAL ATHLETIC HEALTH HISTORY
(2017-2018 School Year)

Student Name: _____

DOB: _____/_____/_____ Grade: _____

Date form completed: _____/_____/_____

Health History to Be Completed by Parent/Guardian

Answer questions below to indicate if your child has or has ever had the following.

Provide details to any 'yes' answer on back.

	YES	NO
Ever been restricted by a doctor or nurse practitioner from sports participation for any reason?		
Any ongoing medical condition(s)? ☐Asthma ☐Diabetes ☐Seizures ☐Other ☐Sickle Cell trait or disease		
Ever had surgery?		
Ever spent a night in the hospital?		
Have a life threatening allergy? ☐Medication ☐Food ☐Insect bites ☐Pollen ☐Latex ☐Other		
Carry an epinephrine auto injector?		
Ever passed out during or after exercise?		
Ever complained of light headedness or dizziness during or after exercise?		
Ever complained of chest pain, tightness or pressure during or after exercise?		
Ever complained of fluttering in their chest, skipped beats, or heart racing, or does he/she have a pacemaker?		
Has a health care provider ever had a test by their physician on his/her heart? (EKG, echocardiogram, stress test, etc.)		
Ever been told they have a heart condition or problem?		
Ever had high or low blood pressure?		
Ever complained of getting more tired or short of breath that nis/her friends during exercise?		

	YES	NO
Have stomach problems?		
Ever had a hit to the head that caused headaches, dizziness, nausea, or confusion or been told he/she had a concussion?		
Ever had headaches with exercise?		
Ever had a seizure?		
Currently being treated for a seizure disorder or epilepsy?		
Ever been unable to move his/her arms and legs, or had tingling numbness or weakness after being hit or falling?		
Use a brace, orthotic or other device?		
Have any problems with his/her hearing or wear hearing aids?		
Have any special devices or protheses (insulin pump, glucose sensor, ostomy bag, etc.)?		
Wear glasses or contacts?		
Ever had a hernia?		
Does he/she have only 1 functioning kidney?		
Deos he/she have a bleeding disorder?		
Females Only Has she had her period? At what age did it begin? _____	**YES**	**NO**
Date of last menstrual period: _____		
Males Only Does he have only one testicle?	**YES**	**NO**

	YES	NO
Ever been tolf by their health care provider they have asthma?		
Use or carry an inhaler or nebulizer?		
Ever become ill while exercising in hot weather?		

	YES	NO
Does your child have to avoid any certain foods?		

Preparticipation/Interval Athletic Health History

Please explain fully any question you answered 'Yes: to in the space below (Print clearly and provide any dates, if known):

_____

_____

_____

_____

_____

_____

_____

_____

I certify to the best of my knowledge my answers are complete and true.

Parent/Guardian Signature: _____ Date: _____

Reviewed by (Name and Title): _____

Date: _____ **Office number: 518-673-6334 / Fax: 518-673-6322**

DISTRICT OFFICE 673-6302
. . . . . Fax: 673-3177
Mrs. Deborah P. Grimshaw
Superintendent

HIGH SCHOOL 673-6330
. . . . . .Fax: 673-3177
Ms. Rebecca Gleason,
High School Principal

MIDDLE SCHOOL 673-6320
. . . . . .Fax: 673-5557
Mr. Mark Rauch
Middle School Principal

EAST HILL ELEM. SCHOOL. 673-6310
. . . . . .Fax: 673-3887
Ms. Stacy Ward Elementary Principal

DIR. OF SPECIAL ED. 673-6317
. . . . . .Fax: 673-4131
Mrs. Jennifer Schwabrow

ELEM./MID. SCHOOL NURSE 673-6314
. . . . . .Fax: 673-3887
Mrs. Haley Ferguson, L.P.N

HS NURSE 673-6334
. . . . . .Fax: 673-3177
Mrs. Alicia Downs, R.N

ATHLETICS 673-6302
. . . . . Fax: 673-6309
Mr. Brian Dunn,
Coordinator