

School Health Services



INTERVAL HEALTH HISTORY FOR SPORTS PARTICIPATION

SCHOOL NAME: Webutuck Central School District

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 Modified
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:

Allergies (Bee Sting/Medications/Food/Latex,etc.) Yes No
Does the student carry an Epi-pen[®] for a life-threatening allergy? (Need MD Order) Yes No

Asthma Yes No
Does the student carry an inhaler? (Need MD Order) Yes No

Concussion/Head injury/Seizures Yes No
Recent injury that requires medical attention or protective equipment? Yes No
Recent illness lasting longer than one week (ie. Mono) Yes No
Currently taking medications Yes No
Diabetes/Hypoglycemia Yes No
Heart/Blood Pressure Problems Yes No
Heat Exhaustion or Stroke Yes No
Hearing Impairment Yes No
Bleeding Tendency/Anemia Yes No
Recent Surgery or Hospitalization Yes No
Kidney/Liver Disease Yes No
Contact Lenses Yes No
Is there any medical condition that might be aggravated by playing sports? 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".

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

