Student Name:    Check	AUCE	'D I+-		- lab- 115-a								
Student Name:   DOB:   School Name:   Age:     School Name:   Age:     School Name:   Age:     School Name:   Age:   School Name:   Age:   School Name:   Age:   School Name:   Age:   School Name:   Sch	NYSED Interval Health History for Athletics											
School Name:  Grade (check):												
Grade (check):	Student Name:	DOB:										
Sport: Limitations:   Yes   No   Date of last health exam: Date form completed:  Health History to Be Completed by Parent/Guardian, Provide Details to Any Yes Answers on Back. Medicines needed at practice and/or athletic event require the proper paperwork, contact school with questions.  Has/Does your child:  General Health Concerns   No   Yes   1. Ever been restricted by a health care provider from sports participation for any reason?  2. Have an ongoing medical condition?   Asthma   Diabetes   Seizures   Sickle Cell trait or disease   Other   3. Ever had surgery?	School Name:			Age:								
Date of last health exam:    Date form completed:	Grade (check): $\Box$ 7 $\Box$ 8 $\Box$ 9 $\Box$ 10	□11	□12	Level (check): ☐ Modified ☐ Fresh ☐ JV ☐	Varsi	ty						
Health History to Be Completed by Parent/Guardian, Provide Details to Any Yes Answers on Back.  Medicines needed at practice and/or athletic event require the proper paperwork, contact school with questions.  Has/Does your child:  General Health Concerns  No Yes  1. Ever been restricted by a health care provider from sports participation for any reason?  2. Have an ongoing medical condition?  Asthma   Diabetes   Seizures   Sickle Cell trait or disease   Other  3. Ever had surgery?  4. Ever spent the night in a hospital?  5. Been diagnosed with Mononucleosis within the last month?  6. Have only one functioning kidney?  7. Have a bleeding disorder?  9. Have any problems with his/her hearing or wears hearing ald(s)?  9. Have any problems with his/her vision or has vision in only one eye?  10. Wear glasses or contacts?  Allergies  11. Have a life-threatening allergy? Check any that apply: Prood   Insect Bite   Latex   Medicine   Pollen   Other  12. Carry an epinephrine auto-injector?  Breathing (Respiratory) Health  No Yes  14. Wheeze or cough frequently during or after exercise?  14. Wheeze or cough frequently during or after exercise?  Has/Does your child:  Concussion/ Haed Injury History  No Yes  17. Ever had a hist to the head that caused headache, dizziness, nausea, confusion, or been told he/she had a concussion?  18. Ever had a hist of the head that caused headache, dizziness, nausea, confusion, or been told he/she had a concussion?  19. Ever had a hist of the head that caused headache, dizziness, nausea, confusion, or been told he/she had a concussion?  19. Ever had a head injury or concussion?  19. Ever had any unexplained seizures?  20. Ever had any unexplained seizures?  21. Currently receive treatment for a seizure disorder or epilepsy?  Devices/Accommodations  No Yes  22. Use a brace, orthotic, or other device?  23. Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.): If yes, there may be need for another required form to be filled out.  24. Wear protective eyewear,	Sport:			Limitations: ☐ Yes ☐ No								
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Concussion/ Head Injury History   No   Yes		-										
Concussion/ Head Injury History   No   Yes	Has/Does your child:			Has/Does your child:								
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Seizures   Sickle Cell trait or disease   Other	2. Have an ongoing medical condition?		·		Ш	Ш						
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□ Food □ Insect Bite □ Latex □ Medicine □ Pollen □ Other  12. Carry an epinephrine auto-injector?  Breathing (Respiratory) Health No Yes  13. Ever complained of getting more tired or short of breath than his/her friends during exercise?  14. Wheeze or cough frequently during or after exercise?  □ Insect Bite □ Latex cardiomyopathy, long QT or short QT syndrome, or catecholaminergic polymorphic ventricular tachycardia?  Females Only  Sequence of Segun having her period?  26. Begun having her period?  27. Age periods began:  28. Have regular periods?  29. Date of last menstrual period:  Males Only  No Yes												
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14. Wheeze or cough frequently during or after exercise?  29. Date of last menstrual period:  Males Only  No Yes	•				_	_						
after exercise? No Yes												
Ividies Offiy				·								
15 Ever been told by a health care	15. Ever been told by a health care			-	No	Yes						
one identifier they have actions 2	•											
16. Use or carry an inhaler or nebulizer? 31. Have groin pain or a bulge or hernia in the groin?	provider they have asthma?	ΙШ		30. Have only one testicle?								

			Page 2				
Student Name:			0.5 _				
School Name:		DOB:					
Has/Does your child:			Has/Does your child:				
Heart Health	No	Yes	Injury History continued	No	Yes		
32. Ever passed out during or after exercise?			39. Ever been unable to move his/her arms and legs, or had tingling, numbness, or				
<ul><li>33. Ever complained of light headedness or dizziness during or after exercise?</li><li>34. Ever complained of chest pain, tightness or pressure during or after</li></ul>			weakness after being hit or falling?  40. Ever had an injury, pain, or swelling of joint that caused him/her to miss practice or a game?				
exercise?  35. Ever complained of fluttering in their chest, skipped beats, or their heart			<ul><li>41. Have a bone, muscle, or joint injury that bothers him/her?</li><li>42. Have joints become painful, swollen,</li></ul>				
racing, or does he/she have a			warm, or red with use?	No	Vac		
pacemaker?  36. Ever had a test by a health care			<b>Skin Health</b> 43. Currently have any rashes, pressure	No	Yes		
provider for his/her heart (e.g. EKG, echocardiogram stress test)?		Ш	sores, or other skin problems?  44. Have had a herpes or MRSA skin	H			
37. Ever been told they have a heart cond		a alcall	infections?  Stomach Health	No.	L Vas		
or problem by a health care provider? If so, check all that apply:  ☐ Heart infection ☐ Heart Murmur ☐ High Blood Pressure ☐ Low Blood Pressure ☐ High Cholesterol ☐ Kawasaki Disease			45. Ever become ill while exercising in hot weather?  46. Have a special diet or need to avoid certain foods?	No .	Yes		
□Other:			47. Have to worry about his/her weight				
Injury History	No	Yes	48. Have stomach problems?				
38. Ever been diagnosed with a stress fracture?			49. Ever had an eating disorder?				
COVID-19 Information				No	Yes		
50. Has your child ever tested positive for	COVID-	19?					
51. Was your child symptomatic?							
52. Did your child see a healthcare provid							
53. Did your child have any cardiac symptoms (new fast or slow heart rate, chest tightness or pain, blood pressure changes, or HCP diagnosed cardiac condition)? If yes, please provide additional information.							
54. Was your child hospitalized? If yes, provide date(s)?							
If yes, was your child diagnosed with Multisystem Inflammatory syndrome (MISC)?							
If yes, is your child under a HCP's	care for	this?					
Please explain fully any question yo Use additional pages if necessary.	u answ	vered y	es to in the space below, include dates i	if knov	wn.		
Parent/Guardian Signature:			Date:				