~ GROTON CENTRAL SCHOOL ~

INTERVAL HEALTH HISTORY FOR SPORTS PARTICIPATION

PLEASE RETURN FORM TO THE SCHOOL HEALTH OFFICE

Must be completed and signed by parent/guardian prior to physical exam and prior to each sport season.

PART A:

Name: ________________________________ **Age:** ________ **Date of Birth** ___/___/ ___ **Grade:** _____

Sport: ________________________________ **Level: Var JV Mod Limitations: yes no**

Date of last Physical _____/_____/_____

PART B: HISTORY SINCE LAST HEALTH APRAISAL - TO BE COMPLETED BY PARENT OR GUARDIAN

For any "Yes" answers: Please describe in PART C and COMPLETE OTHER SIDE.

	YES	NO		YES	NO
1. Any injuries requiring medical attention			5. Change in wearing glasses or contacts?		
2. Any illness lasting more than 5 days?			6. Any surgical operations or fractures?		
3. Taking medicine or under physician's care at this time?			7. Any treatment in a hospital or emergency room?		
4. Any feeling of faintness, dizziness or fatigue after exercise or exertion?			8. Developed any allergies?		
			9. Any chronic disease?		

***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 the school 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.**

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 clearly understand these questions are asked 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. I WILL INORM THE MIDDLE-HIGH SCHOOL HEALTH DEPARTMENT OF ANY INJURIES OR ILLNESSES PRIOR TO OR DURING THIS SPORT SEASON.

SIGNED:____ **Date:** _____/_____/_____

PART E: TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE

Sports participation (check one): Approved Referred to School Physician

SIGNED:____ **Date:** _____/_____/_____

School Health Office

If referred to the School Physician (check one): Requalified Disqualified

SIGNED:____ **Date:** _____/_____/_____

~ OVER ~

Side two to be completed if sports physical to be done at school

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ATHETIC INTERIM HEALTH HISTORY

Student's Name: ____

Please answer the following questions, and explain all "Yes" answers below:

1. **Has the athlete had any injury or serious illness since his/her last yearly physical?__________**
2. **Any ongoing or chronic illness? __________ If yes, any worsening or improvement in that illness? __________**
3. **Any overnight hospitalization since the last physical? __________**
4. **Any surgery since the last physical? __________**
5. **Is the athlete taking any new medications since the last physical? __________**
6. **Any new rashes, hives, skin problems or allergies since the last physical? __________**
7. **Any episodes of lightheadedness, dizziness or fainting since the last physical? __________**
8. **Any chest pain during or after exercise? __________**
9. **Any new or changing heart murmur or other heart problems since the last physical? __________**
10. **Has the athlete developed any high blood pressure? __________**
11. **Has the athlete had any head injury or concussion since the last physical? __________**
12. **Any seizures since the last physical? __________**
13. **Any new, worsening, different or more frequent headaches since the last physical? __________**
14. **Is the athlete having any numbness or tingling in his/her arms, legs, hands or feet? __________**
15. **Does the athlete have asthma? __________ If yes, any worsening or improvement? __________**
    a. **Is the athlete under the care of a physician for the asthma? __________**
       - If yes, physician's name & phone number: ____
    b. **What medications is the athlete on?**
       ____
    c. **Does the athlete take their inhale with them to every practice & game? __________**
    d. **Does the athlete have a current order from the physician allowing them to do so? __________**
       (Self-carry orders by physician must be co-signed by parent/guardian)
16. **If the athlete does not have asthma, has the athlete developed any cough, wheeze, chest discomfort or shortness of breath during or after activity? __________**
17. **Is the athlete using any new protective or corrective equipment? _________**
18. **Has the athlete developed any new problems with vision or hearing? __________**
19. **Any new or worsening back or neck problems since the last physical? __________**
20. **Any broken bones, strains, sprains, or pains in joints or bones since the last physical? __________**
21. **Has any blood relative ever developed a heart problem/died of a heart problem before the age of 50? ________**
22. **If female, has the athlete missed three or more menses in a row in the last year? __________**
    - **(If no menses yet, please mark N/A)**
    - **If yes, which months? ____________________**

PLEASE EXPLAIN ALL "YES" ANSWERS TO ABOVE QUESTIONS:

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Parent/Guardian signature: ______________________________ Daytime Telephone: _________________

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