INTERVAL HEALTH HISTORY

Brighton Central School District

Please complete form prior to sports tryout and submit to **NURSE**. Complete the following questions, explain below if needed

Student Name:_____Sport:_____

School:_____Homeroom:_____Grade:_____ ☐ Male ☐ Female

Name of Parent/Guardian:_____

Address and zip code:_____

Home phone:_____Mom cell# _____

Work phone:_____Dad cell# _____

Parent email:_____

Emergency contact name (not parent):_____

Emergency contact phone:_____ Cell#_____

Physician's name:_____ Phone:_____

Dentist's name:_____ Phone: _____

Insurance carrier _____Insurance ID #_____

Preferred hospital:_____Date of birth:_____

Date entered 9th Grade:_____ (leave blank if not applicable)

Participation in sports involves a certain degree of risk for injury. Injury can occur in any sport and vary in nature. Injuries can be minor such as bruises and scrapes or they can be more severe, such as fractures, dislocations, concussions, paralysis and even fatalities. I have carefully read and understand the questions. To the best of my knowledge there is no existing condition that should exclude my son/daughter from athletic participation. My signature constitutes my permission for my child to participate in the above named sport. I understand that the District does not assume responsibility for lost or broken corrective lenses or orthodontic devices. In the event of an emergency, my signature constitutes permission for my child to receive medical evaluation and treatment to ensure his/her health and safety.

If your child is currently under the care of a physician or has an existing illness or injury, they must provide a note of clearance for sports participation from their private physician.

YES	NO	
		1. Any illness or injury since last check up?
		2. Any surgery or overnight hospitalization?
		3. Allergies to medications, insects, food, latex?
		4. Currently taking medications, supplements (prescription or over the counter), or using inhaler? List below.
		5. Missing organ (eye, kidney and/or testicle)?
		6. Chest pain, racing heart, dizziness, fainting with exercise?
		7. Family history of heart problems or death before age 50?
		8. Head injury, unconsciousness or concussion?
		9. Severe viral infection (mono, myocarditis) in last month?
		10. Chronic cough, wheeze, trouble breathing or Asthma?
		11. Convulsions, seizures?
		12. Heatstroke/Exhaustion?
		13. Wear glasses, contact lenses, braces, dental bridges?
		14. Any contagious skin conditions?
		15. Broken bones, joint injuries, muscle/tendon problems?
		16. Compromised hearing or problems with hearing?
		17. Numbness/tingling in extremities? or Swelling/ Pain?
		18. Any special equipment or devices not usually used in your sport (knee brace, foot orthotics, etc.)?
		19. Abdominal problems or unexplained weight change?
		20. Lose weight regularly for your sport?
		21. Special diet/eating disorder? Laxatives/diuretics?
		22. Ever been restricted from sports by a physician?
		23. Have you ever had anemia, bleeding problems, or any other blood problem?
		24. Do you have diabetes or other metabolic medical condition?
		25. Do you have any medical concerns you would like to discuss with your doctor?

For Females only

Age of first menstrual period _ Recent change in periods? ___Yes ___No

Date of most recent period ___ Periods ☐ <21 or ☐ >35 days apart?

Explain:_____

Parent Signature _____ **Date** _____

Student Signature _____ **Date** _____

FOR SCHOOL NURSE USE ONLY

Date of Last Physical Exam _____ **Date of Last tetanus** _____ **Nurse Signature** _____ **Date** _____