

Sachem CSD NYSED Interval Health History for Athletics		
Student Name:	DOB	
School Name:	Age	
Grade (check): <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12	Limitations: <input type="checkbox"/> NO <input type="checkbox"/> YES	
Sport	Date of last Health Exam:	
Sport Level: <input type="checkbox"/> Modified <input type="checkbox"/> Fresh <input type="checkbox"/> JV <input type="checkbox"/> Varsity	Date form completed:	
<b>MUST be completed and signed by Parent/Guardian - Give details to any YES answers on the last page.</b>		

DOES OR HAS YOUR CHILD		
GENERAL HEALTH	No	Yes
Ever been restricted by a health care provider from sports participation for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>
Been diagnosed with mononucleosis within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
Have only one functioning kidney?	<input type="checkbox"/>	<input type="checkbox"/>
Have a bleeding disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Have any problems with hearing or have congenital deafness?	<input type="checkbox"/>	<input type="checkbox"/>
Have any problems with vision or only have vision in one eye?	<input type="checkbox"/>	<input type="checkbox"/>
Have an ongoing medical condition?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, check all that apply:		
<input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Seizures <input type="checkbox"/> Sickle cell trait or disease <input type="checkbox"/> Other:		
Have Allergies?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, check all that apply		
<input type="checkbox"/> Food <input type="checkbox"/> Insect Bite <input type="checkbox"/> Latex <input type="checkbox"/> Medicine <input type="checkbox"/> Pollen <input type="checkbox"/> Other:		
Ever had anaphylaxis?	<input type="checkbox"/>	<input type="checkbox"/>
Carry an epinephrine auto-injector?	<input type="checkbox"/>	<input type="checkbox"/>
BRAIN/HEAD INJURY HISTORY	No	Yes
Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told they had a concussion?	<input type="checkbox"/>	<input type="checkbox"/>
Receive treatment for a seizure disorder or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had migraines?	<input type="checkbox"/>	<input type="checkbox"/>

DOES OR HAS YOUR CHILD		
BREATHING	No	Yes
Ever complained of getting extremely tired or short of breath during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Use or carry an inhaler or nebulizer?	<input type="checkbox"/>	<input type="checkbox"/>
Wheeze or cough frequently during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Ever been told by a health care provider they have asthma or exercise-induced asthma?	<input type="checkbox"/>	<input type="checkbox"/>
DEVICES / ACCOMMODATIONS	No	Yes
Use a brace, orthotic, or another device?	<input type="checkbox"/>	<input type="checkbox"/>
Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
Wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
Wear a hearing aid or cochlear implant?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Let the coach/school nurse know of any device used.</b> <b>Not required for contact lenses or eyeglasses.</b>		
DIGESTIVE (GI) HEALTH	No	Yes
Have stomach or other GI problems?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Have a special diet or need to avoid certain foods?	<input type="checkbox"/>	<input type="checkbox"/>
Are there any concerns about your child's weight?	<input type="checkbox"/>	<input type="checkbox"/>
INJURY HISTORY	No	Yes
Ever been unable to move their arms or legs or had tingling, numbness, or weakness after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had an injury, pain, or swelling of a joint that caused them to miss practice or a game?	<input type="checkbox"/>	<input type="checkbox"/>
Have a bone, muscle, or joint that bothers them?	<input type="checkbox"/>	<input type="checkbox"/>
Have joints that become painful, swollen, warm, or red with use?	<input type="checkbox"/>	<input type="checkbox"/>
Ever been diagnosed with a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>

Student Name:		DOB:	
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DOES OR HAS YOUR CHILD		
Ever complained of:		
Ever had a test by a health care provider for their heart (e.g., EKG, echocardiogram, stress test)?	<input type="checkbox"/>	<input type="checkbox"/>
Lightheadedness, dizziness, during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain, tightness, or pressure during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Fluttering in the chest, skipped heartbeats, heart racing?	<input type="checkbox"/>	<input type="checkbox"/>
Ever been told by a health care provider they have or had a heart or blood vessel problem?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, check all that apply:		
<input type="checkbox"/> Chest Tightness or Pain <input type="checkbox"/> Heart infection <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Murmur <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> New fast or slow heart rate <input type="checkbox"/> Kawasaki Disease <input type="checkbox"/> Has implanted cardiac defibrillator (ICD) <input type="checkbox"/> Has a pacemaker <input type="checkbox"/> Other:		

DOES OR HAS YOUR CHILD		
<b>FEMALES ONLY</b>	No	Yes
Have regular periods?	<input type="checkbox"/>	<input type="checkbox"/>
<b>MALES ONLY</b>	No	Yes
Have only one testicle?	<input type="checkbox"/>	<input type="checkbox"/>
Have groin pain or a bulge, or a hernia?	<input type="checkbox"/>	<input type="checkbox"/>
<b>SKIN HEALTH</b>	No	Yes
Currently have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had a herpes or MRSA skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
<b>COVID-19 INFORMATION</b>		
Has your child ever tested positive for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
If <b>NO, STOP.</b> Go to Family Heart Health History. If <b>YES,</b> answer questions below:		
Date of positive COVID test:		
Was your child symptomatic?	<input type="checkbox"/>	<input type="checkbox"/>
Did your child see a health care provider for their COVID-19 symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
Was your child hospitalized for COVID?	<input type="checkbox"/>	<input type="checkbox"/>
Was your child diagnosed with Multisystem Inflammatory Syndrome (MISC)?	<input type="checkbox"/>	<input type="checkbox"/>

FAMILY HEART HEALTH HISTORY	
A relative has/had any of the following: Check all that apply:	
<input type="checkbox"/> Enlarged Heart/ Hypertrophic Cardiomyopathy/ Dilated Cardiomyopathy <input type="checkbox"/> Arrhythmogenic Right Ventricular Cardiomyopathy? <input type="checkbox"/> Heart rhythm problems, long or short QT interval? <input type="checkbox"/> Brugada Syndrome? <input type="checkbox"/> Catecholaminergic Ventricular Tachycardia? <input type="checkbox"/> Marfan Syndrome (aortic rupture)? <input type="checkbox"/> Heart attack at age 50 or younger? <input type="checkbox"/> Pacemaker or implanted cardiac defibrillator (ICD)?	
A family history of:	
<input type="checkbox"/> Known heart abnormalities or sudden death before age 50? <input type="checkbox"/> Structural heart abnormality, repaired or unrepaired? <input type="checkbox"/> Unexplained fainting, seizures, drowning, near drowning, or car accident before age 50?	

GO to page 3 and please sign and date below	
Parent/Guardian Signature:	Date:

Student Name:		DOB:	
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If you answered **YES** to any questions give details. Sign and date below.

Parent/Guardian Signature:	Date:

**Risk Acknowledgement and Permission:**

I give permission for \_\_\_\_\_ to participate in any sports for which the examining physician or school nurse have determined there are no disqualifying conditions. I fully understand that my child may not participate in any practice, scrimmage, or contest without proper clearance. Further, I acknowledge that with participation in interscholastic athletics comes the risk of injury. These risks vary from sport to sport and can range from minor to catastrophic in nature. In addition, I also recognize that there are risks involved with team travel to contest sites at opposing school facilities. I give permission for my child to undergo a medical examination by district approved physicians. If I choose to have the examination performed by a family physician, then I agree to have the information completed on the appropriate school forms. I also agree that in some cases, district appointed physicians shall have the right to review the information provided my family physicians and retain the right of final approval. I clearly understand that the questions are asked in order to decide if this student is in proper condition to participate sports named at the top of this form. The answers are correct as of the date this form is signed. All answer will be kept confidential in his/her record in the school health office. I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_