Warsaw Central School District - NYSED Interval Health History for Athletics

Student Name:	DOB:
School Name:	Age:
Grade (check): ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12	Limitations: ☐ NO ☐ YES
Sport	Date of last Health Exam:
Sport Level: ☐ Modified ☐ Fresh ☐ JV ☐ Varsity	Date form completed:

MUST be completed and signed by Parent/Guardian - Give details to any YES answers on the last page.

Does or Has Your Child

General Health	No	Yes
Ever been restricted by a health care provider from sports participation for any reason?		
Ever had surgery?		
Ever spent the night in a hospital?		
Been diagnosed with mononucleosis within the last month?		
Have only one functioning kidney?		
Have a bleeding disorder?		
Have any problems with hearing or have congenital deafness?		
Have any problems with vision or only have vision in one eye?		
Have an ongoing medical condition?		
If yes, check all that apply: ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Sickle cell trait or disease ☐ Other:		
Have Allergies?		
If yes, check all that apply ☐ Food ☐ Insect Bite ☐ Latex ☐ Medicine ☐ Pollen ☐ Other:		
Ever had anaphylaxis?		
Carry an epinephrine auto-injector?		
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?		
Receive treatment for a seizure disorder or epilepsy?		
Ever had headaches with exercise?		
Ever had migraines?		

Does or Has Your Child

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

Student Name:		DOB:	

Does or Has Your Child

Heart Health

Ever complained of:

Ever had a test by a health care provider for their heart (e.g., EKG, echocardiogram, stress test)?	☐	☐
Lightheadedness, dizziness, during or after exercise?	☐	☐
Chest pain, tightness, or pressure during or after exercise?	☐	☐
Fluttering in the chest, skipped heartbeats, heart racing?	☐	☐
Ever been told by a health care provider they have or had a heart or blood vessel problem?	☐	☐

If yes, check all that apply:

- ☐ Chest Tightness or Pain
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ New fast or slow heart rate
- ☐ Has implanted cardiac defibrillator (ICD)
- ☐ Has a pacemaker
- ☐ Other:
- ☐ Heart infection
- ☐ Heart Murmur
- ☐ Low Blood Pressure
- ☐ Kawasaki Disease

Does or Has Your Child

Females Only	No	Yes
Have regular periods?	☐	☐
Males Only	**No**	**Yes**
Have only one testicle?	☐	☐
Have groin pain or a bulge, or a hernia?	☐	☐
Skin Health	**No**	**Yes**
Currently have any rashes, pressure sores, or other skin problems?	☐	☐
Ever had a herpes or MRSA skin infection?	☐	☐
COVID-19 Information		
Has your child ever tested positive for COVID-19?	☐	☐
If **NO, STOP.** Go to Family Heart Health History. If **YES,** answer questions below:		
Date of positive COVID test:		
Was your child symptomatic?	☐	☐
Did your child see a health care provider for their COVID-19 symptoms?	☐	☐
Was your child hospitalized for COVID?	☐	☐
Was your child diagnosed with Multisystem Inflammatory Syndrome (MISC)?	☐	☐

Family Heart Health History

A relative has/had any of the following:

Check all that apply:

- ☐ Enlarged Heart/ Hypertrophic Cardiomyopathy/ Dilated Cardiomyopathy
- ☐ Arrhythmogenic Right Ventricular Cardiomyopathy?
- ☐ Heart rhythm problems, long or short QT interval?
- ☐ Brugada Syndrome?
- ☐ Catecholaminergic Ventricular Tachycardia?
- ☐ Marfan Syndrome (aortic rupture)?
- ☐ Heart attack at age 50 or younger?
- ☐ Pacemaker or implanted cardiac defibrillator (ICD)?

A family history of:

- ☐ Known heart abnormalities or sudden death before age 50?
- ☐ Structural heart abnormality, repaired or unrepaired?
- ☐ Unexplained fainting, seizures, drowning, near drowning, or car accident before age 50?

If you answered **NO** to ***all*** questions, **STOP**. Sign and date below.
GO to page 3 if you answered **YES** to a question.

Parent/Guardian Signature:	Date:

Student Name:		DOB:	

If you answered **YES** to any questions give details. Sign and date below**.**	
Parent/Guardian Signature:	Date: