Mechanicville City School District

NYSED Interval Health History for Athletics - Both Pages must be completed ~ 30 day update

Student Name:	**DOB:**
Grade: 7 8 9 10 11 12	**Level:** Modified Fresh JV Varsity
Sport:	**Date of last health exam:**

Health History to be Completed by Parent/Guardian, Provide Details to any YES Answers on Back.

Medicines needed at practice and/or athletic events require the proper **"MAY CARRY"** order from your physician.

Has/Does your child:

General Health Concerns	**YES**	**NO**
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/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?		
8. Have any problems with his/her hearing or wears hearing aid(s)		
9.Have any problems with his/her vision or has vision in only one eye?		
10. Wear glasses or contacts?		

Allergies	**YES**	**NO**
11. Have a life-threatening allergy? Circle any that apply: Food Insect Bite Latex Medicine Pollen Other		
12. Carry an epinephrine-auto injector?		

Breathing (Respiratory) Health	**YES**	**NO**
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?		
15. Ever been told by a health care provider they have asthma?		
16. Use or carry an inhaler or nebulizer?		

Has/Does your child:

Concussion/Head Injury History	**YES**	**NO**
17. Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told he/she had a concussion?		
18. Ever had a head injury or concussion?		
19. Ever had headaches with exercise?		
20. Ever had any unexplained seizures?		
21. Currently receiving treatment for a seizure disorder or epilepsy?		

Devices/Accommodations	**YES**	**NO**
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 is another required form to be filled out.		
24. Wear protective eyewear, such as goggles or a face shield?		

Family History	**YES**	**NO**
25. Have any relative who's been diagnosed with a heart condition, such as a murmur, developed hypertrophic cardiomyopathy, Marfan Syndrome, Brugada Syndrome, right ventricular cardiomyopathy, long QT or short QT syndrome, or catecholaminergic polymorphic ventricular tachycardia?		

Females Only	**YES**	**NO**
26. Begun having her period?		
27. Age periods began:		
28. Have regular periods?		
29. Date of last menstrual period:		

Males Only	**YES**	**NO**
30. Have only one testicle?		
31. Have groin pain or a bulge or hernia in the groin?		

Student Name: **DOB:**

Has/Does your child:		
Heart Health	**YES**	**NO**
32. Ever passed out during or after exercise?		
33. Ever complained of lightheadedness or dizziness during or after exercise?		
34. Ever complained of chest pain, tightness or pressure during or after exercise?		
35. Ever complained of fluttering in their chest, skipped beats, or their heart racing, or does he/she have a pacemaker?		
36. Ever had a test by a health care provider for his/her heart (ex. EKG, echocardiogram stress test)?		
37. Ever been told they have a heart condition or problem by a health care provider? Heart infection — Heart murmur High blood pressure — Low blood pressure High Cholesterol — Kawasaki disease Other:		
Injury History	**YES**	**NO**
38. Ever been diagnosed with a stress fracture?		
39. Ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling?		

Has/Does your child:		
Injury History continued	**YES**	**NO**
40. Ever had an injury, pain, or swelling of a joint that caused him/her to miss practice or a game?		
41. Have a bone, muscle, or joint injury that bothers him/her?		
42. Have joints become painful, swollen, wam or red with use?		
Skin Health	**YES**	**NO**
43. Currently have any rashes, pressure sores, or other skin problems?		
44. Have had a herpes or MRSA skin infection?		
Stomach Health	**YES**	**NO**
45. Ever become ill while exercising in hot weather?		
46. Have a special diet or need to avoid certain foods?		
47. Have to worry about his/her weight?		
48. Have stomach problems?		
49. Ever had an eating disorder?		

COVID-19 Information	**YES**	**NO**
50. Has your child ever tested positive for COVID-19? Dates:		
51. Was your child symptomatic?		
52. Did your child see a healthcare provider (HCP) for their COVID-19 symptoms?		
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 dates:		
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 questions your answered YES to in the space below, include dates if known.

_____

_____

_____

_____

Parent/Guardian Signature: _____ **Date:** _____