



SPORT: _____

CITY SCHOOL DISTRICT OF NEW ROCHELLE
515 NORTH AVENUE
NEW ROCHELLE, NEW YORK 10801-3416

INTERVAL ATHLETIC HEALTH HISTORY

Name: _____ DOB: _____

School: _____ Grade: _____

Parents/Guardians must complete and sign this form in pen. Return completed forms to the School Nurse.

As required by the New York State Education Department, an annual physical exam and Athletic Health History is required in order for a student to participate in intramural athletics. An Interval Athletic Health History is required for each new season. The School Nurse and/or Medical Director determines if further evaluation or documentation is required for medical clearance for participation.

Note to School Nurses:

- A student should not be cleared if there has been an absence of >5 days, unless the illness was not sports related and will not compromise the student's participation. Notes from the student's medical provider may be necessary.
- Sports related injuries require notes from the treating medical provider (ex: orthopedist).
- In unclear situations, refer the student for reexamination.

For any YES response, please explain.

1. How many days have you been absent since participating in your last sport? _____ days

Reason: _____

2. Have you had any illness, surgery, or hospitalization since participating in your last sport? YES [] NO []

Describe: _____

3. Have you had any accident or injury during or since participating in your last sport? YES [] NO []

Describe: _____

4. Have you visited your doctor or an Emergency Room for any reason since participating in your last sport? YES [] NO []

Describe: _____

5. Are you taking any medication(s)? YES [] NO []

List: _____

6. During participation in your last sport, have you gotten unusually out of breath, had chest pains headaches, palpitations, or dizziness? YES [] NO []

Describe: _____

7. Have you ever fainted during exercise? YES [] NO []

8. Has any family member under age 50 died suddenly or due to heart disease? YES [] NO []

Please give the cause, if known: _____

9. Have you lost, due to trauma or disease, an eye, a kidney, or a testicle? YES [] NO []

By signing and submitting this form, I attest that I have fully disclosed all of my child's requested medical information/history. Parent assumes liability for non-disclosure of such information. The Medical Director has final authority to medically clear students for interscholastic sports participation.

Parent/Guardian Name: _____ Parent/Guardian Signature: _____ Date: _____

Cell Phone #: _____ Email address _____

FOR HEALTH OFFICE USE ONLY:

[] Approved for participation

[] Referred to School Physician _____

School Nurse

Date

Rev 6/18