**SPORT:**

CITY SCHOOL DISTRICT OF NEW ROCHELLE

# INTERVAL ATHLETIC HEALTH HISTORY

Name:_______________________________________ Date:__________________

School:_______________________________________ DOB:__________________

Sport:_______________________________________ Grade:__________________

**This Interval Athletic Health History must be completed in pen, signed by a parent/guardian and returned to the School Nurse.**

**Note to parents:** As required by the New York State Education Department, a physical exam is performed annually in order for a student to participate in intramural athletics. Our School Physician or Nurse Practitioner must clear each student athlete and specify in which categories of sports he or she may compete. For each new season, the parent and student are required to complete the Interval Athletic Health History. It will be reviewed by the School Nurse and referred to the School Physician if necessary. The School Physician will determine whether further evaluation is required.

**Note to School Nurses:**

A. 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 family physician may be necessary.

B. Sports related injuries require notes from the orthopedist, family physician or the School Physician.

C. In unclear situations, schedule the students for reexamination.

## MEDICAL HISTORY

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 illnesses 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? 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 40 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 School District Physician has final authority to medically clear students for interscholastic sports participation.

Student's signature:___________________________ Date:_________

Parent's signature:___________________________ Date:_________ Cell Phone #: _____________ e-mail address _______________

**FOR HEALTH OFFICE USE ONLY:**

[ ] Approved for participation

[ ] Referred to School Physician ________________________________________

School Nurse Date

SP3 (REV. 10/12)