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 <u>in pen.</u> 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 <u>not</u> 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