City School District of New Rochelle - Interval Athletic Health History

To Be Completed and Signed By Parent/Guardian

Student Name:	DOB:	Today's Date:
School:	Grade (check): ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12	Age:
Sport:	Level (check): ☐ Modified ☐ Fresh ☐ JV ☐ Varsity	

General Health Concerns	**Yes**	**No**
1. Ever been restricted from sports by a doctor?		
2. Has an ongoing medical condition? ☐ Asthma ☐ Sickle Cell trait or disease ☐ Seizures ☐ Diabetes ☐ Other		
3. Currently takes medications?		
4. Ever had surgery?		
5. Ever spent the night in a hospital?		
6. Mononucleosis within the last month?		
7. Have only one functioning kidney?		
8. Have a bleeding disorder?		
9. Have problems hearing or wears hearing aid(s)?		
10. Has vision problems/vision in only one eye?		
11. Wear glasses or contacts?		
Allergies	**Yes**	**No**
12. Has a life threatening allergy? Check applicable: ☐ Food ☐ Insect Bite ☐ Latex ☐ Medication ☐ Pollen ☐ Other:		
13. Carries an epinephrine auto-injector?		
Breathing (Respiratory) Health	**Yes**	**No**
14. Ever complained of getting more tired or short of breath than peers during exercise?		
15. Wheeze or cough frequently during or after exercise?		
16. Ever diagnosed with asthma?		
17. Use or carry an inhaler or nebulizer?		
Females Only	**Yes**	**No**
18. Ever had a menstrual period?		
19. Has regular periods?		
20. Age periods began:		
21. Date of last menstrual period (LMP):		
Males Only	**Yes**	**No**
22. Has only one testicle?		
23. Has groin pain, a bulge, or hernia in the groin?		
Devices/Accommodations (*special form needed)	**Yes**	**No**
24. Uses a brace, orthotic, or other device?		
25. Has an insulin pump, glucose sensor, ostomy?	*	
26. Wears protective eyewear/goggles/face shield?		

Concussion/Head Injury History	**Yes**	**No**
27. Ever had a head injury or Concussion?		
28. Ever had a hit to the head/body causing headache, dizziness, nausea, confusion?		
29. Ever had headaches with exercise?		
30. Ever had any unexplained seizures?		
31. Currently treated for seizures or epilepsy?		
Heart Health	**Yes**	**No**
32. Ever passed out during or after exercise?		
33. Ever complained of light headedness or dizziness during or after exercise?		
34. Ever complained of chest pain, tightness or pressure during or after exercise?		
35. Ever complained of chest fluttering, skipped beats, heart racing, or has a pacemaker?		
36. Ever had a heart test done by a medical provider (EKG, echocardiogram, stress test)?		
37. Ever been diagnosed with a heart condition: ☐Heart Infection ☐Heart Murmur ☐High Blood Pressure ☐Low Blood Pressure ☐High Cholesterol ☐Kawasaki Disease ☐Other:		
Injury History	**Yes**	**No**
38. Ever diagnosed with a stress fracture?		
39. Ever been unable to move arms/legs or had tingling, numbness or weakness after being hit or falling?		
40. Ever missed a practice or game due to a joint injury, pain or swelling?		
41. Has a bothersome bone, muscle or joint?		
42. Has joint pain, swelling, warmth or redness with use/activity?		
Skin Health	**Yes**	**No**
43. Currently has skin rashes, sores, or ulcers?		
44. Has had a herpes or MRSA skin infection?		
Stomach Health	**Yes**	**No**
45. Ever become ill exercising in hot weather?		
46. Has a special diet or avoids certain foods?		
47. Worries about own weight?		
48. Has stomach problems?		
49. Ever had an eating disorder?		

Family Heart History: Any relative with a murmur, hypertrophic or right ventricular cardiomyopathy, Marfan or Brugada Syndrome, long or short QT syndrome, catecholaminergic polymorphic ventricular tachycardia?	**Yes**	**No**

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

Provide a ***Medication Administration Form*** for any medication to be taken during practice or events