

School Physician Signature _____
Date Cleared _____
Date of Last Sports Physical _____

School Nurse Signature _____

Scotia-Glenville C.S.D.
Interval Health History Form for Sports Participation

Prior to the start of tryout sessions or practice at the beginning of each season, a health history review for each student must be completed and turned in to the health office.

Part A- TO BE COMPLETED BY THE STUDENT

Student Name _____ Date of Birth _____
Grade _____ Age _____
Sport _____ **Modified JV/Varsity** (Please circle one)

Part B-TO BE COMPLETED BY THE PARENT OR GUARDIAN

NOTE: "YES" to any of these questions does not mean automatic disqualification from participation in sports. However, it will require a review and approval by the school physician before the student can report to practice or tryouts.

HISTORY SINCE LAST HEALTH APPRAISAL

If the answer to any of the following questions is "YES," please describe the condition or situation that prompted your answer, giving the date and doctor clearance in Part C.

- | | | | | |
|-----|---|-----|----|------------|
| 1. | Any injuries requiring medical attention including, concussion or loss of consciousness? | YES | NO | DATE _____ |
| 2. | Any illness lasting more than 5 days? | YES | NO | DATE _____ |
| 3. | Currently taking medication or under the care of a physician for an active problem? | YES | NO | DATE _____ |
| 4. | Any feelings of faintness, dizziness, fatigue, or chest pain after exercise or exertion? | YES | NO | DATE _____ |
| 5. | Change in wearing glasses or contact lenses? | YES | NO | DATE _____ |
| 6. | Any fractures or surgical procedures? | YES | NO | DATE _____ |
| 7. | Any treatment in a hospital or emergency room? | YES | NO | DATE _____ |
| 8. | Developed any allergies, asthma exercise induced asthma or reactions to medication? | YES | NO | DATE _____ |
| 9. | Any chronic disease? (Diabetes, bleeding disorder Seizures?) | YES | NO | DATE _____ |
| 10. | Problems with heat exhaustion/heat fatigue? | YES | NO | DATE _____ |
| 11. | Absence of or the significant impairment of one of a pair of organs? (kidney, eye, ear, testicle) | YES | NO | DATE _____ |
| 12. | Any history of sudden death in a family member under the age of 50? | YES | NO | DATE _____ |

PART C- TO BE COMPLETED BY PARENT OR GUARDIAN

Describe the condition or situation that caused you to answer "YES" to any question in PART B.

PART D-PARENTAL PERMISSION

I, the undersigned, clearly understand these questions are asked in order to decide if my child can safely participate in the athletic sport named in PART A of this form. The answers are correct as of this date and he/she has my permission to participate.

SIGNED _____ DATE _____