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| **Athletic Health History Form** |
| Student Name: | DOB: Age: |
| School Name: |
| Grade: 7 8 9 10 11 12 | Limitations: NO YES |
| Sport: | Date of last Health Exam: |
| Sport Level: Modified JV Varsity | Date this form is completed:  |
| **MUST** **be completed and signed by** **Parent/Guardian** – Give details to any **YES answers** on the **LAST page.** |

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| SINCE YOUR CHILD’S **LAST HEALTH EXAM** – HAS YOUR CHILD? |
| **GENERAL HEALTH** | **NO** | **YES** |
| Been restricted by a health care provider from sports participation for any reason? | □ | □ |
| Had Surgery? | □ | □ |
| Spent the night in a hospital? | □ | □ |
| Been diagnosed with mononucleosis within the last month? | □ | □ |
| Had/has only one functioning kidney? | □ | □ |
| Had/has a bleeding disorder? | □ | □ |
| Had/has any problems with hearing or have congenital deafness? | □ | □ |
| Had/has any problems with vision or only have vision in one eye? | □ | □ |
| Been diagnosed with a new medical condition? | □ | □ |
| **If yes, check all that apply:*** Asthma
* Seizures
* Diabetes
 | * Sickle cell trait or disease
* Other:
 |
| Developed allergies? | □ | □ |
| **If yes, check all that apply:*** Food
* Medicine
* Pollen
 | * Latex
* Insect Bite
* Other:
 |
| Had anaphylaxis? | □ | □ |
| Carried an epinephrine auto-injector? | □ | □ |
| Had/has groin pain, a bulge, or a hernia? | □ | □ |
| **DEVICES / ACCOMMODATIONS** | **NO** | **YES** |
| Used/uses a brace, orthotic, or another device? | □ | □ |
| Had special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)? | □ | □ |
| Worn protective eyewear, such as goggles or a face shield?  | □ | □ |
| Worn a hearing aid or cochlear implant? | □ | □ |
| **Let the coach/school nurse know of any device used. Note required for contact lenses or eyeglasses.** |

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| SINCE YOUR CHILD’S **LAST HEALTH EXAM** – HAS YOUR CHILD? |
| **BRAIN/HEAD INJURY HISTORY** | **NO** | **YES** |
| Had a hit to the head that caused headache, dizziness, nausea, confusion, or been told they had a concussion? | □ | □ |
| Received treatment for a seizure disorder or epilepsy? | □ | □ |
| Had headaches with exercise? | □ | □ |
| Has/had migraines? | □ | □ |
| **BREATHING** | **NO** | **YES** |
| Complained of getting extremely tired or short of breath during exercise? | □ | □ |
| Used or carries an inhaler or nebulizer? | □ | □ |
| Has/had wheezing or coughing frequently during or after exercise? | □ | □ |
| Been told by a health care provider they have asthma or exercise induced asthma? | □ | □ |
| **DIGESTIVE (GI) HEALTH** | **NO** | **YES** |
| Has/had stomach or other GI problems? | □ | □ |
| Has an eating disorder? | □ | □ |
| Has a special diet or need to avoid certain foods? | □ | □ |
| Do you have concerns about your child’s weight? | □ | □ |
| **INJURY HISTORY** | **NO** | **YES** |
| Been unable to move their arms or legs or had tingling, numbness, or weakness after being hit or falling? | □ | □ |
| Had an injury, pain, or joint swelling causing them to miss practice or a game? | □ | □ |
| Has/had a bone, muscle, or joint that bothers them? | □ | □ |
| Has/had joints that become painful, swollen, warm, or red with use? | □ | □ |
| Been diagnosed with a stress fracture? | □ | □ |

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| Student Name: | Grade: | DOB: |

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| SINCE YOUR CHILD’S **LAST HEALTH EXAM** – HAS YOUR CHILD? |
| **FEMALES ONLY** | **NO** | **YES** |
| Had a change in period frequency related to female athlete triage? | □ | □ |
| **MALES ONLY** | **NO** | **YES** |
| Been diagnosed with only having one testicle? | □ | □ |
| **SKIN HEALTH** | **NO** | **YES** |
| Had/has any rashes, pressure sores, or other skin problems? | □ | □ |
| Had/has herpes or MRSA skin infection? | □ | □ |
| **COVID-19** | **NO** | **YES** |
| Tested positive for COVID-19? | □ | □ |
| **IF NO, STOP** & move onto the **Heart History** section.**IF YES** answer the questions below: |
| Date of positive COVID test: |
| Was your child symptomatic? | □ | □ |
| Did your child see a healthcare provider for their COVID-19 symptoms? | □ | □ |
| Was your child hospitalized for COVID? | □ | □ |
| Was your child diagnosed with Multisystem Inflammatory Syndrome (MIS)? | □ | □ |

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| SINCE YOUR CHILD’S **LAST HEALTH EXAM** – HAS YOUR CHILD? |
| **HEART HISTORY** | **NO** | **YES** |
| Had a test by a healthcare provider for their heart (EKG, echocardiogram, stress test, etc.)? | □ | □ |
| Had/has lightheadedness or dizziness during or after exercise? | □ | □ |
| Has/had chest pain, tightness, or pressure during or after exercise? | □ | □ |
| Had/has fluttering in the chest, skipped heartbeats, or heart racing? | □ | □ |
| Been told by a healthcare provider they had/have a heart or blood vessel problem? | □ | □ |
| **If yes, check all that apply:*** Chest Tightness/Pain
* High Blood Pressure
* Low Blood Pressure
* New Fast Heart Rate
* New Slow Heart Rate
* Has Implanted Cardiac Defibrillator (ICD)
* Has/had a pacemaker implanted
 | * Heart infections
* Heart murmur
* High Cholesterol
* Kawasaki Disease
* Other:
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| Since your child’s **last health exam** – check any **NEW Family Heart Health History** |
| A relative had or is currently experiencing any of the following since your child’s **last health exam,** check all that apply: |
| * Enlarged heart / Hypertrophic Cardiomyopathy / Dilated Cardiomyopathy
* Arrhythmogenic Right Ventricular Cardiomyopathy
* Hearth rhythm problems: long or short QT intervals
* Structural heart abnormality, repaired or unrepaired
* Known heart abnormalities or sudden death before age 50
 | * Brugada Syndrome
* Catecholaminergic Ventricular Tachycardia
* Marfan Syndrome (Aortic Rupture)
* Heart Attack at age 50 or younger
* Pacemaker or implanted cardiac defibrillator (ICD)
* Unexplained fainting, seizures, drowning, near drowning, or severe car accident before age 50
 |
| Parent/Guardian Signature: Date: |
| Please sign and date above. If you answered **NO to ALL questions, STOP!**If you answered **YES** to any question, **move on to page 3.**ALL INFORMATION ON THIS FORM IS ***NEW INFORMATION*** SINCE YOUR CHILD’S **LAST HEALTH EXAMINATION.** |

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| Student Name: | Grade: | DOB: |

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| If you answered **YES** to any questions, please give as many details as possible.**Sign and date below.** |
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| Parent/Guardian Signature: | Date: |

