

NYSED Interval Health History for Athletics—Two Page Form

Both pages mus	st be completed.
Student Name:	DOB:
School Name:	Age:
Grade (check): □ 7 □ 8 □ 9 □ 10 □ 11 □ 12	Level (check): ☐ Modified ☐ Fresh ☐ JV ☐ Varsity
Sport:	Limitations: ☐ Yes ☐ No
Date of last health exam:	Date form completed:

Health History To Be Completed By Parent/Guardian, Provide Details To Any Yes Answers On Back.

Any medications to be taken at practice and/or athletic event will require the proper paperwork, contact school with questions.

	Has/Does your child:		
Gen	eral Health Concerns	Yes	No
1.	Ever been restricted by a doctor,		
	physician assistant, or nurse		
	practitioner from sports participation		
	for any reason?		
2.	Have an ongoing medical condition?		
	☐ Asthma ☐ Diabetes		
	☐ Seizures ☐ Sickle Cell trait or disea	ase	
	☐ Other		
3.	Ever bad surgery?		
_	Ever spent the night in a hospital?		
5.	Been diagnosed with Mononucleosis		
	within the last month?		l
	Have only one functioning kidney?		
	Have a bleeding disorder?		
8.	Have any problems with his/her		
_	hearing or wears hearing aid(s)?		
9.	Have any problems with his/her vision	1	O'Contrad de Contrado de Contr
10	or has vision in only one eye?		
Allei	Wear glasses or contacts?	Yes	No
24 10 10 10 10	Have a life threatening allergy?	res	INO
11.	Check any that apply:		
	Food Insect Bite		
	□ Latex □ Medicine		
	□ Pollen □ Other		
17	Carry an epinephrine auto-injector?	<u></u>	
	thing (Respiratory) Health	Yes	No
_	Ever complained of getting more tired	163	.40
Jan. Age 3	or short of breath than his/her friends		
	during exercise?		
14	Wheeze or cough frequently during or		
4 7 1			
4.7,	after exercise?	I .	8
	Ever been told by their health care	-	der term
			To the state of th

	Has/Does your child:		
Con	cussion/ Head Injury History	Yes	No
17.	Ever had a hit to the head that caused		
	headache, dizziness, nausea, confusion,		0777
	or been told he/she had a concussion?		1
18.	Have you ever had a head injury or		
	concussion?		1
19.	Ever had headaches with exercise?		Г
20.	Ever had any unexplained seizures?		
21.	Currently receive treatment for a		
	seizure disorder or epilepsy?		<u> </u>
Dev	ices/Accommodations	Yes	No
22.	Use a brace, orthotic, or other device?		
23.	Have any special devices or prostheses		
	(insulin pump, glucose sensor, ostomy		
	bag, etc.)? If yes there may be need for		
	another required form to be filled out.		L.,_
24.	Wear protective eyewear, such as		
	goggles or a face shield?		
Fam	illy History	Yes	No
25.	Have any relative who's been		
	diagnosed with a heart condition,		
	such as a murmur, developed		
	hypertrophic cardiomyopathy,		
	Marfan Syndrome, Brugada Syndrome,		
	right ventricular cardiomyopathy,		
	long QT or short QT syndrome, or		
	catecholaminergic polymorphic		
	ventricular tachycardia?		1
	ales Only	Yes	No
	Begun having her period?		
	Age periods began:		
	Have regular periods?		
	Date of last menstrual period:		-
Mal	es Only	Yes	No
30.	Have only one testicle?		
30.	Have only one testicle? Have groin pain or a bulge or hernia in the groin?	The state of the s	

itudent Name:					
School Name:			DOB:		
scrioor Name.			000.		
			The state of the s		_
Has/Does your child:			Has/Does your child:		
eart Health	Yes	No		Yes	No
Ever passed out during or after exercise?			39. Ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling?		
3. Ever complained of light headedness or dizziness during or after exercise?	F 9		40. Ever had an injury, pain, or swelling of		
Ever complained of chest pain, tightness or pressure during or after			joint that caused him/her to miss practice or a game?		
exercise? 5. Ever complained of fluttering in their			41. Have a bone, muscle, or joint injury that bothers him/her?		
chest, skipped beats, or their heart racing, or does he/she have a			42. Have joints become painful, swollen, warm, or red with use?		
pacemaker?			Skin Health	Yes	No
6. Ever had a test by their medical			43. Currently have any rashes, pressure		
provider for his/her heart (e.g. EKG,			sores, or other skin problems?		
echocardiogram stress test)?			44. Have had a herpes or MRSA skin		
Ever been told they have a heart cond	ition		infections?		
or problem by a physician?			Stomach Health	Yes	No
If so, check all that apply:			45. Ever become ill while exercising in hot		
☐ Heart infection ☐ Heart Murr			weather?		<u> </u>
☐ High Blood Pressure ☐ Low Blood		re	46. Have a special diet or have to avoid certain foods?		
☐ High Cholesterol ☐ Kawasaki D	sease				-
Other:			47. Have to worry about his/her weight?		
njury History	Yes	No	48. Have stomach problems?		
8. Ever been diagnosed with a stress fracture?	agnosed with a stress 49. Have you ever had an eating disorder?				
	II.				
ease explain fully any question y ovide dates if known.	ou ar	iswered	yes to in the space below. (Please print of	clearly	and
				15-	
					-

Parent/Guardian Signature: ______Date: _____