DeRUYTER CENTRAL SCHOOL
INTERVAL HEALTH HISTORY FOR SPORTS PARTICIPATION

Prior to the start of tryout sessions or practice at the beginning of each season, a health history review for each athlete must be conducted unless the student received a full medical examination within 30 days of the start of the season.

PART A: <u>TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE</u>

Student: _____ Date of Birth: _____

Grade: _____ Age: _____

Sport: _____

Date of last health appraisal: _____ Limitations: ❑ Yes ❑ No

_____

PART B: <u>TO BE COMPLETED BY THE PARENT/GUARDIAN</u>

Note: "Yes" to any of these questions does not mean automatic disqualification from the athletic activity indicated in PART A above. However, it may require a review and approval by the school physician before the student can report to practice or tryouts. The answers to the questions on this form will be held in the school health office, and will be kept confidential.

<u>HISTORY SINCE LAST HEALTH APPRAISAL:</u>

If the answer to any of the following questions is "YES", in PART C on the reverse side of this form, please describe the condition or situation that prompted your answer.

1. Any injuries requiring medical attention?	❑ Yes ❑ No
2. Any illness lasting more than five (5) days?	❑ Yes ❑ No
3. Taking medicine or under physician's care at this time?	❑ Yes ❑ No
4. Any feeling of faintness, dizziness or fatigue after exercise or exertion?	❑ Yes ❑ No
5. Change in wearing glasses or contact lenses?	❑ Yes ❑ No
6. Any surgical operations or fractures?	❑ Yes ❑ No
7. Any treatment in a hospital or emergency room?	❑ Yes ❑ No
8. Developed any allergies?	❑ Yes ❑ No
9. Any chronic disease?	❑ Yes ❑ No

PART C: <u>TO BE COMPLETED BY PARENT OR GUARDIAN</u>

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

_____

_____

_____

_____

_____

PART D: <u>PARENTAL PERMISSION</u>

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

SIGNED: _____ DATE: ___/___/___

Telephone Numbers: Home: _____ Cell: _____

Work: _____ Beeper: _____

Emergency Contact: Name: _____ #: _____

PLEASE RETURN TO THE SCHOOL NURSE

PART E: <u>TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE</u>

Sports Participation:

❑ Approved ❑ Referred to School Physician

Signed: _____ Date: ___/___/___
School Health Office

If referred to the School Physician:

❑ Requalified ❑ Disqualified

Signed: _____ Date: ___/___/___
School Physician