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| **Interval Health History for Athletics**  |
| Student Name: |   | DOB: |   |
| School Name: |   | Age: |   |
| Grade (check): [ ] 7 [ ]  8 [ ]  9 [ ]  10 [ ]  11 [ ]  12 | Limitations: [ ]  NO [ ]  YES |
| Sport:  |   | Date of last Health Exam: |   |
| Sport Level: [ ] Modified [ ]  Fresh [ ]  JV [ ]  Varsity | Date form 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? |
| Brain/Head Injury History  | No | Yes |
| Has or had a hit to the head that caused headache, dizziness, nausea, or confusion, or been told they had a concussion? |[ ] [ ]
| Received treatment for a seizure disorder or epilepsy? |[ ] [ ]
| Has or had headaches with exercise? |[ ] [ ]
| Has or had migraines? |[ ] [ ]
| Breathing | No | Yes |
| Complained of getting extremely tired or short of breath during exercise? |[ ] [ ]
| Used or carries an inhaler or nebulizer? |[ ] [ ]
| Has or 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 or 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 caused them to miss practice or a game? |[ ] [ ]
| Has or had a bone, muscle, or joint that bothers them? |[ ] [ ]
| Has or had joints that become painful, swollen, warm, or red with use? |[ ] [ ]
|  Been diagnosed with a stress fracture? |[ ] [ ]
| Females Only | No | Yes |
| Change in period frequency related to female athlete triad? |[ ] [ ]

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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? |[ ] [ ]
| Has only one functioning kidney? |[ ] [ ]
| Has or had a bleeding disorder? |[ ] [ ]
| Having problems with hearing or have congenital deafness? |[ ] [ ]
| Having problems with vision or only have vision in one eye? |[ ] [ ]
| Been diagnosed with a new medical condition? |[ ] [ ]
| If yes, check all that apply:[ ]  Asthma [ ]  Diabetes[ ]  Seizures [ ]  Sickle cell trait or disease[ ]  Other: |
| Developed Allergies? |[ ] [ ]
| If yes, check all that apply[ ]  Food [ ]  Insect Bite [ ]  Latex [ ]  Medicine [ ]  Other: [ ]  Pollen |
| Had anaphylaxis? |[ ] [ ]
| Carry an epinephrine auto-injector? |[ ] [ ]
| Had or has groin pain, a bulge, or a hernia? |[ ] [ ]
| Devices / Accommodations | No | Yes |
| Uses a brace, orthotic, or another device? |[ ] [ ]
| Has special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)? |[ ] [ ]
| Wears protective eyewear, such as goggles or a face shield? |[ ] [ ]
| Wears a hearing aid or cochlear implant? |[ ] [ ]
| **Let the coach/school nurse know of any device used. Not required for contact lenses or eyeglasses.** |

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| Student Name: |   | DOB: |   |

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| Since your child’s last health exam –Has Your Child? |
| Heart Health | No | Yes |
| Had a test by a health care provider for their heart (e.g., EKG, echocardiogram, stress test)? |[ ] [ ]
| Has or had lightheadedness or dizziness during or after exercise? |[ ] [ ]
| Has or had chest pain, tightness, or pressure during or after exercise?  |[ ] [ ]
| Has or had fluttering in the chest, skipped heartbeats, heart racing? |[ ] [ ]
| Been told by a healthcare provider they have or had a heart or blood vessel problem? |[ ] [ ]
| **If yes, check all that apply:** |
| [ ]  Chest Tightness or Pain [ ]  High Blood Pressure[ ]  Low Blood Pressure[ ]  New fast or slow heart rate  | [ ]  Heart Infections[ ]  Heart Murmur[ ]  High Cholesterol[ ]  Kawasaki Disease  |
| [ ]  Has implanted cardiac defibrillator (ICD)[ ]  Had a pacemaker implanted |
| [ ]  Other:  |
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| Since your child’s last health exam – Has Your Child? |
| Males Only | No | Yes |
| Has only one testicle? |[ ] [ ]
| Skin Health | No | Yes |
| Has any rashes, pressure sores, or other skin problems? |[ ] [ ]
| Has a herpes or MRSA skin infection? |[ ] [ ]
| COVID-19 Information | No | Yes |
| Child tested positive for COVID-19?   |[ ] [ ]
| **NO, STOP** and go to Family Heart Health History.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 (MISC)?  |[ ] [ ]

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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: |
| Check all that apply: |  |
| [ ]  Enlarged Heart/ Hypertrophic Cardiomyopathy/ Dilated Cardiomyopathy[ ] Arrhythmogenic Right Ventricular Cardiomyopathy?[ ]  Heart rhythm problems: long or short QT interval?[ ]  Structural heart abnormality, repaired or unrepaired? | [ ]  Brugada Syndrome?[ ]  Catecholaminergic Ventricular Tachycardia?[ ]  Marfan Syndrome (aortic rupture)?[ ]  Heart attack at age 50 or younger?[ ]  Pacemaker or implanted cardiac defibrillator (ICD)?  |
| [ ]  Known heart abnormalities or sudden death before age 50? [ ]  Unexplained fainting, seizures, drowning, near drowning, or car accident before age 50? |
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| If you answered **NO** to ***all*** questions, **STOP**. Sign and date below.**GO** to page 3 if you answered **YES** to a question. |
| [ ]  **Information on this form is NEW information since my child’s last health examination.** |
| Parent/GuardianSignature: |   | Date: |   |

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| Student Name: |   | DOB: |   |

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