Office Use Only

School Physician Signature _____ School Nurse Signature _____

Date Cleared _____

Date of Last Sports Physical _____

# Scotia-Glenville Central School District
# 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 since last physical 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 medical director before the student can report to practice or tryouts.

## HISTORY SINCE LAST PHYSICAL

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 healthcare provider clearance in Part C. **(circle your answer, enter date where applicable)**

| | |
|---|---|
| Any injuries requiring medical attention including concussion or loss of consciousness? Yes No Date _____ | Diagnosed with chronic condition/disease such as diabetes, bleeding disorder, seizures? Yes No Date |
| Any illness lasting more than 5 days? Yes No Date | Absence of or the significant impairment of one of a pair of organs (kidney, eye, ear, testicle)? Yes No Date |
| Currently taking medication or under the care of a healthcare provider for an active problem? Yes No Date | Problems with heat exhaustion/heat fatigue? Yes No Date |
| Any feelings of faintness, dizziness, fatigue or chest pain after exercise or exertion? Yes No Date | Any history of sudden death in a family member under the age of 50? Yes No Date |
| Change in wearing glasses or contact lenses? Yes No Date | Has your child ever tested positive for COVID-19? Yes No Date |
| Any fractures or surgical procedures? Yes No Date | Was your child symptomatic with diagnosis of COVID-19? Yes No Date |
| Any treatment in a hospital or emergency room? Yes No Date | Did your child see a healthcare provider (HCP) for their COVID-19 symptoms? Yes No Date |
| Developed any allergies, asthma, exercise induced asthma or reactions to medications? Yes No Date | Did your child have any cardiac symptoms (new fast or slow heart rate, chest tightness or pain, blood pressure changes or diagnosed cardiac condition? Yes No Date (if yes please provide additional information) |
| Any special diet or need to avoid certain foods? Yes No Date If yes, what are your child's special dietary needs? _____ _____ | Was your child hospitalized? If yes, provide date(s) Yes No Date If yes, was your child diagnosed with Multisystem Inflammatory Syndrome? Yes No Date If yes, is your child under a HCP's care for this? 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.

_____

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## PART D-PARENTAL PERMISSION

I, the undersigned, clearly understand these questions are asked 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 my child has my permission to participate.

SIGNED_____ DATE_____