South Orangetown Central School District

160 Van Wyck Road, Blauvelt, NY 10913
TZHS Nurse: 845-680-1647 Fax: 845-680-1960 SOMS Nurse: 845-680-1130 Fax: 845-680-1911

PREPARTICIPATION/INTERVAL ATHLETIC HEALTH HISTORY – Two Page Form

Student Name:_____DOB:_____/___/_____

Current Grade: _____

Sport: _____

Date of last health exam:_____/_____/_____Limitations: ❑ Yes ❑ No Date form completed____/___/_____

Health History To Be Completed By Parent/Guardian

Answer questions below to indicate if your child has or has ever had the following.
Provide details to any yes answer on back:

	YES	NO
Ever been restricted by a doctor or nurse practitioner from sports participation for any reason?		
Have an ongoing medical condition? Please check below: ⌋ Asthma □ Diabetes □Seizures ⌋ Other □ Sickle Cell trait or disease		
Ever had surgery?		
Ever spent the night in a hospital?		
Have a life threatening allergy? ⌋ Medication □ Food □ Insect bites ⌋ Pollen □Latex □ Other		
Carry an epinephrine auto-injector)?		
Ever passed out during or after exercise?		
Ever complained of light headedness or dizziness during or after exercise?		
Ever complained of chest pain, tightness or pressure during or after exercise?		
Ever complained of fluttering in their chest, skipped beats, or their heart racing, or does s/he have a pacemaker?		
Has a health care provider ever has a test by their physician for his/her heart? (eg. EKG, echocardiogram, stress test)		
Ever been told they have a heart condition or problem?		
Ever had high or low blood pressure?		
Ever complained of getting more tired or short of breath than his/her friends during exercise?		
Wheeze or cough frequently during or after exercise?		
Ever been told by their health care provider they have asthma?		
Use or carry an inhaler or nebulizer?		
Ever become ill while exercising in hot weather?		
On a special diet or have to avoid certain foods?		
Have to worry about their weight?		

	YES	NO
Have stomach problems?		
Ever had a hit to the head that caused a headache, dizziness, nausea, or confusion, or been told s/he had a concussion?		
Ever have headaches with exercise?		
Ever had a seizure?		
Currently being treated for a seizure disorder or epilepsy?		
Ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling?		
Ever an injury, pain, or swelling of joint that caused him/her to miss practice or a game?		
Use a brace, orthotic or other device?		
Have any problems with his/her hearing or wear hearing aids?		
Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)?		
Have any problems with his/her vision or have vision in one eye only?		
Wear glasses or contacts?		
Ever had a hernia?		
Does s/he have only 1 functioning kidney?		
Does s/he have a bleeding disorder?		
Females Only	**YES**	**NO**
Has she had her period? At what age did it begin?		
How often does she get her period?		
Date of last menstrual period		
Males Only	**YES**	**NO**
Does he have only one testicle?		
Family History	**YES**	**NO**
Has any relative been diagnosed with a heart condition or developed hypertrophic cardiomyopathy, Marfan Syndrome, right ventricular cardiomyopathy, long QT or short QT syndrome, Brugada Syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
Has any relative died suddenly before the age of 50 from unknown or heart related cause?		

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Student Name:_____ DOB:_____/_____/_____

Please explain fully any question you answered yes to in the space below (Please print clearly, and provide dates if known):

I certify that to the best of my knowledge my answers are complete and true.

Parent/Guardian Signature:_____ Date: _____

Reviewed by (Name and Title):_____ Date:_____