Cortland Jr-Sr High School

INTERVAL HEALTH HISTORY FOR SPORTS PARTICIPATION

Prior to the start of each sport 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 –

Student: _____ Age: _____

Grade (check): ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 Date of Birth: ____/____/____

Sport: _____ Level (check): ☐ Var ☐ JV ☐ Frosh ☐ Mod

Date of last Health Appraisal: ____/____/____ Limitations: ☐ Yes ☐ No

PART B –

NOTE: "YES" to any of these questions does not mean disqualification from the athletic activity indicated in PART A above. However, it will 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.

HISTORY SINCE LAST HEATLH APPRAISAL:

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.

	(CHECK)	
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 lens?	☐ 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 – TO BE COMPLETED BY PARENT OR GUARDIAN

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

_____

_____

PART D – PARENTAL/GUARDIAN PERMISSION

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.

SIGNED:_____ DATE:____/____/____

PLEASE RETURN TO THE SCHOOL NURSE'S OFFICE

PART E – TO BE COMPLETED BY THE SCHOOL NURSE'S OFFICE

Sports Participation (check):

☐ Approved ☐ Referred to School Physician

Signed:_____ Date:____/____/____

School Health Office

If referred to the School Physician (check):

☐ Requalified ☐ Disqualified

Signed:_____ Date:____/____/____

School Physician