

Kingston City School District
 NYSED Interval Health History for Athletics—Two Page Form

Both pages must be completed in blue or black ink.

For all JV, Varsity, and Freshman: Return to Kingston High School between July 19th and August 15th

For Modified: Return to Kingston High School between August 5th and August 15th / AFTER AUGUST 15th – RETURN TO HOME SCHOOL

| | |
|---|--|
| Student Name: | DOB: |
| School Name: | Age: |
| Grade (check): <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 | Level (check): <input type="checkbox"/> Modified <input type="checkbox"/> Fresh <input type="checkbox"/> JV <input type="checkbox"/> Varsity |
| Sport: | Limitations: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Date of last health exam: | Date form completed: |

Health History To Be Completed By Parent/Guardian, Provide Details To Any Yes Answers On Back.

Any medications to be taken at practice and/or athletic event will require the proper paperwork, contact school with questions.

| Has/Does your child: | | |
|---|-----|----|
| General Health Concerns | Yes | No |
| 1. Ever been restricted by a doctor, physician assistant, or nurse practitioner from sports participation for any reason? | | |
| 2. Have an ongoing medical condition? <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Seizures <input type="checkbox"/> Sickle Cell trait or disease <input type="checkbox"/> Other | | |
| 3. Ever had surgery? | | |
| 4. Ever spent the night in a hospital? | | |
| 5. Been diagnosed with Mononucleosis within the last month? | | |
| 6. Have only one functioning kidney? | | |
| 7. Have a bleeding disorder? | | |
| 8. Have any problems with his/her hearing or wears hearing aid(s)? | | |
| 9. Have any problems with his/her vision or has vision in only one eye? | | |
| 10. Wear glasses or contacts? | | |
| Allergies | Yes | No |
| 11. Have a life threatening allergy? Check any that apply: <input type="checkbox"/> Food <input type="checkbox"/> Insect Bite <input type="checkbox"/> Latex <input type="checkbox"/> Medicine <input type="checkbox"/> Pollen <input type="checkbox"/> Other | | |
| 12. Carry an epinephrine auto-injector? | | |
| Breathing (Respiratory) Health | Yes | No |
| 13. Ever complained of getting more tired or short of breath than his/her friends during exercise? | | |
| 14. Wheeze or cough frequently during or after exercise? | | |
| 15. Ever been told by their health care provider they have asthma? | | |
| 16. Use or carry an inhaler or nebulizer? | | |

| Has/Does your child: | | |
|--|-----|----|
| Concussion/ Head Injury History | Yes | No |
| 17. Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told he/she had a concussion? | | |
| 18. Have you ever had a head injury or concussion? | | |
| 19. Ever had headaches with exercise? | | |
| 20. Ever had any unexplained seizures? | | |
| 21. Currently receive treatment for a seizure disorder or epilepsy? | | |
| Devices/Accommodations | Yes | No |
| 22. Use a brace, orthotic, or other device? | | |
| 23. Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)? If yes there may be need for another required form to be filled out. | | |
| 24. Wear protective eyewear, such as goggles or a face shield? | | |
| Family History | Yes | No |
| 25. Have any relative who's been diagnosed with a heart condition, such as a murmur, developed hypertrophic cardiomyopathy, Marfan Syndrome, Brugada Syndrome, right ventricular cardiomyopathy, long QT or short QT syndrome, or catecholaminergic polymorphic ventricular tachycardia? | | |
| Females Only | Yes | No |
| 26. Begun having her period? | | |
| 27. Age periods began: | | |
| 28. Have regular periods? | | |
| 29. Date of last menstrual period: | | |
| Males Only | Yes | No |
| 30. Have only one testicle? | | |
| 31. Have groin pain or a bulge or hernia in the groin? | | |

Student Name: _____

School Name: _____

DOB: _____

| Has/Does your child: | | |
|---|------------|-----------|
| Heart Health | Yes | No |
| 32. Ever passed out during or after exercise? | | |
| 33. Ever complained of light headedness or dizziness during or after exercise? | | |
| 34. Ever complained of chest pain, tightness or pressure during or after exercise? | | |
| 35. Ever complained of fluttering in their chest, skipped beats, or their heart racing, or does he/she have a pacemaker? | | |
| 36. Ever had a test by their medical provider for his/her heart (e.g. EKG, echocardiogram stress test)? | | |
| 37. Ever been told they have a heart condition or problem by a physician? If so, check all that apply: <input type="checkbox"/> Heart infection <input type="checkbox"/> Heart Murmur <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Kawasaki Disease <input type="checkbox"/> Other: _____ | | |
| Injury History | Yes | No |
| 38. Ever been diagnosed with a stress fracture? | | |

| Has/Does your child: | | |
|--|------------|-----------|
| Injury History <i>continued</i> | Yes | No |
| 39. Ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling? | | |
| 40. Ever had an injury, pain, or swelling of joint that caused him/her to miss practice or a game? | | |
| 41. Have a bone, muscle, or joint injury that bothers him/her? | | |
| 42. Have joints become painful, swollen, warm, or red with use? | | |
| Skin Health | Yes | No |
| 43. Currently have any rashes, pressure sores, or other skin problems? | | |
| 44. Have had a herpes or MRSA skin infections? | | |
| Stomach Health | Yes | No |
| 45. Ever become ill while exercising in hot weather? | | |
| 46. Have a special diet or have to avoid certain foods? | | |
| 47. Have to worry about his/her weight? | | |
| 48. Have stomach problems? | | |
| 49. Have you ever had an eating disorder? | | |

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

Parent/Guardian Signature: _____ Date: _____