

NEWBURGH ENLARGED CITY SCHOOL DISTRICT – HEALTH SERVICES

INTERVAL HEALTH HISTORY FOR SPORTS PARTICIPATION

SCHOOL NAME: _____

All students participating in Sports must have a physical exam on file for the current school year. Prior to beginning each subsequent season, an Interval Health History must be completed.

PART A:

Student Name: _____ D.O.B: ___/___/___ Age: _____ Grade: _____

ID # _____ Sport: _____ Level: Varsity JV Modified

Date of last health appraisal: ___/___/___ Limitations: _____yes _____no

PART B: TO BE COMPLETED BY THE PARENT OR GUARDIAN

Note: “Yes” to any of these questions below does not mean automatic 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 HEALTH APPRAISAL:

If the answer to any of the following questions is “YES” - on the reverse side of this form in PART C, please describe the condition or situation that prompted your answer.

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 lenses? _____ 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 PERMISSION

To the best of my knowledge, this health interval is correct. I realize that there is a risk of being injured that is inherent in all sports. I realize the risk of injury may be severe, including the risk of fracture, brain injury, paralysis or even death.

Understanding the above, I give permission for my son/daughter _____,
a student in the Newburgh Enlarged City School District to participate in: _____.

SPORT NAME

SIGNED: _____
Parent/Guardian Signature

DATE: _____

Address: _____

Home/Cell phone number: _____

PLEASE RETURN TO THE SCHOOL HEALTH OFFICE

PART E: TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE

Sports Participation:

_____ Approved

_____ Referred to School Physician

Signed: _____
School Health Office NP/SNT/RN Signature

Date: ____/____/____

If referred to the School Physician:

_____ Requalified

_____ Disqualified

Signed: _____
School Physician Signature

Date: ____/____/____