PREPARTICIPATION/INTERVAL ATHLETIC HEALTH HISTORY

FREWSBURG CENTRAL SCHOOL
26 INSTITUTE STREET
FREWSBURG, NEW YORK
Phone: (716) 569-7000

School Name:_____

Student Name:_____

DOB :_____ Grade _____ Sport _____ Level Select One

Date of last health exam: _____ Limitations _____ Select One _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 and provide details to any yes answer on page 2.

Question	Yes	No
Has a doctor or nurse practitioner (a health care provider) ever restricted his/her participation in sports for any reason?	☐	☐
Does s/he have an ongoing medical condition? Please check below: ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Other ☐ Sickle Cell trait or disease	☐	☐
Has s/he ever had surgery?	☐	☐
Has s/he ever spent the night in a hospital?	☐	☐
Does s/he have a life threatening allergy? Please check below: ☐ Medication ☐ Food ☐ Insect Bites ☐ Pollen ☐ Latex ☐ Other	☐	☐
Does s/he carry an Epi-pen (epinephrine)?	☐	☐
Has s/he ever passed out during or after exercise?	☐	☐
Has s/he ever complained of light headedness or dizziness during or after exercise?	☐	☐
Has s/he ever complained of chest pain, tightness or pressure during or after exercise?	☐	☐
Has s/he 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 ordered a test for his/her heart? (ex. EKG, echocardiogram, stress test)	☐	☐
Has s/he been told s/he has a heart condition or problem?	☐	☐
Has s/he ever had high or low blood pressure?	☐	☐
Has s/he ever complained of getting more tired or short of breath than his/her friends during exercise?	☐	☐
Does s/he wheeze or cough frequently during or after exercise?	☐	☐
Has a health care provider ever said s/he has asthma?	☐	☐
Does s/he use or carry an inhaler or nebulizer?	☐	☐
Has s/he ever become ill while exercising in hot weather?	☐	☐
Is s/he on a special diet or have to avoid certain foods?	☐	☐

Question	Yes	No
Does s/he worry about their weight?	☐	☐
Does s/he have stomach problem?	☐	☐
Has s/he ever had a hit to the head that caused a headache, dizziness, nausea, or confusion, or been told s/he had a concussion?	☐	☐
Does s/he ever have headaches with exercise?	☐	☐
Has s/he ever had a seizure?	☐	☐
Is s/he currently being treated for a seizure disorder or epilepsy?	☐	☐
Has s/he ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling?	☐	☐
Has s/he ever had an injury, pain, or swelling of a joint that caused him/her to miss practice or a game?	☐	☐
Does s/he use a brace, orthotic or other device?	☐	☐
Does s/he have any problems with his/her vision or have vision in one eye only?	☐	☐
Does s/he wear glasses or contacts?	☐	☐
Has s/he ever had a hernia?	☐	☐
Does s/he have only 1 functioning kidney?	☐	☐
Does s/he have a bleeding disorder?	☐	☐
Females Only		
Has she had her period? (If yes, please answer next 3 questions) At what age did it begin?	☐	Age
How often does she get her period?		
Date of last menstrual period?		
Males Only		
Does he have only one testicle?	☐	☐
Family History		
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?	☐	☐

PREPARTICIPATION/INTERVAL ATHLETIC HEALTH HISTORY

FREWSBURG CENTRAL SCHOOL
26 INSTITUTE STREET
FREWSBURG, NEW YORK
Phone: (716) 569-7000

School Name:_____

Student Name:_____ DOB :_____

Please explain fully any questions 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

Revised 9/2014

Print Clear Form