Pre - Season Sports Health History Update

Prior to the start of tryout sessions or practice at the beginning of each sport season, a health history review must be conducted and ***returned to the building school nurse*** **(DO NOT GIVE TO COACH)** *or the student will not be cleared to participate. The purpose of this health history is to ensure that* ***any health problems occurring since the las sport season/physical are identified and considered.***

Student Name ____ **Gr.** ____ **Birth date**________________

Date of last Physical ___________ by **Doctor** __________________________ **School Year**__________

Sport _______________________________________ **Today's Date**_______________________

Parent/Guardian ~ answer the following questions regarding your student's health care ***since their last physical***
ANY REQUIRED MEDICATION WILL NEED A PHYSICIAN ORDER ON FILE IN THE NURSE'S OFFICE

	YES	***NO***
1. Has the student ever been told not to participate in a sport for a medical reason?	_____	_____
2. Has anyone in the student's immediate family under age 50 died of heart problems or unexplained causes?	_____	_____
3. Does the student get chest pain, light-headed or faint as a result of exercise?	_____	_____
4. Does the student have asthma?	_____	_____
5. Does the student require a prescribed *inhaler?		
6. Does the student have allergies? (Bee, food, medication etc.)______________________________________	_____	_____
7. Does the student require * medication for the allergy? (Epi-pen, Benadryl etc.)_________________________	_____	_____
8. Does the student take daily * medication?____	_____	_____
9. Has the student had a concussion or skull fracture or lost consiousness?	_____	_____
10. Does the student have any problems with environmental heat (heat fatigue, heat exhaustion, stroke)?	_____	_____
11. Doe the student have absent or significantly impaired organs (kidneys,eyes,ears,testicles)?______________	_____	_____
12. Does the student have any other chronic illness (diabetes, seizures, bleeding disorders etc.)?____________	_____	_____
13. Has the student had any operations since his last physical?	_____	_____
14. Has the student had a fracture, sprain or dislocation since his last physical? _________________________	_____	_____
15. Does the student wear glasses or contacts for sports participation?__________________________________	_____	_____
16. Is he/she currently participating in physical education class without restrictions?	_____	_____

Comments: Please describe in detail and give dates of any of the above medical concerns. _________________________________
____
____

PARENTAL PERMISSION

I, the undersigned, clearly understand the above questions are asked in order to decide if my child can safely participate in the team named above. The answers are truthful, as of the above date. My child has my permission to participate in the above named sport.

Signed ____________________________________ **Relationship** ________________________

For Office use only

Sports Participation Approved - Yes ____ ***No*** ____ ***Referred to Dr. Kravitz*** ______

Initialed ______ ***Kathy Cunningham RN*** Initialed _______ ***Theresa Varsoke RN***

If referred to School Physician:

- ***Qualified*** *to participate*
- ***Disqualified*** *due to* ______________________________________

Signed ______________________________________ ***MD Date*** ____________________