

*Salmon River Central School*

**PREPARTICIPATION/INTERVAL ATHLETIC HEALTH HISTORY**

Student Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Grade (check):  7    8    9    10    11    12

Sport: \_\_\_\_\_ Level (check):  Varsity    JV    Modified

\*\*Parent Signature \_\_\_\_\_ Phone Number \_\_\_\_\_ Date: \_\_\_\_\_

**Health History To Be Completed By Parent/Guardian**

*Explain any **YES** questions on the lines below.*

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: <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Seizures <input type="checkbox"/> Other <input type="checkbox"/> 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: <input type="checkbox"/> Medication <input type="checkbox"/> Food <input type="checkbox"/> Insect bites <input type="checkbox"/> Pollen <input type="checkbox"/> Latex <input type="checkbox"/> 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 have stomach problems?		
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 an injury, pain, or swelling of 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 hearing or wear hearing aides?		
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?		
<b>Females Only</b>	<b>YES</b>	<b>NO</b>
Has she had her period? At what age did it begin? _____		
How often does she get her period?		
Date of last menstrual period _____		
<b>Males Only</b>	<b>YES</b>	<b>NO</b>
Does he have only one testicle?		
<b>Family History</b>	<b>YES</b>	<b>NO</b>
Has any relative died suddenly before the age of 50 from unknown or heart related cause?		

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