Lake Shore Central Schools Interval Health History for Athletics

Front & back MUST be completed and signed by parent/guardian

Student Name:	DOB:
Address:	Phone # :
Grade (check): ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12	Level (check): ☐ Modified ☐ JV ☐ Varsity
Sport:	Current Medications:
Date of last health exam:	Primary Care Physician:

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.

Has/Does your child:

GENERAL HEALTH	YES	NO
1. Ever been restricted by a health care provider from sports participation for any reason?		
2. Have an ongoing medical condition? ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Sickle Cell trait/disease ☐ Other: _____		
3. Ever had surgery?		
4. Ever spent the night in a hospital? If yes, when? _____		
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: ☐ Food ☐ Insect Bite ☐ Latex ☐ Medicine ☐ Pollen ☐ Other: _____		
12. Ever had anaphylaxis?		
13. Carry an epinephrine auto-injector?		
BREATHING (Respiratory) HEALTH	**YES**	**NO**
14. Ever complained of getting extremely tired or short of breath during exercise?		
15. Wheeze or cough frequently during or after exercise?		
16. Use/carry an inhaler or nebulizer?		
17. Ever been told by their health care provider they have asthma or exercise-induced asthma?		

Has/Does your child:

BRAIN/HEAD INJURY History	YES	NO
18. Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told he/she had a concussion?		
19. Ever had migraines?		
20. Ever had headaches with exercise?		
21. Ever had any unexplained seizures?		
22. Ever received treatment for a seizure disorder or epilepsy?		
DEVICES/ACCOMODATIONS	**YES**	**NO**
23. Use a brace, orthotic, or other device?		
24. Have any special devices or prostheses? (insulin pump, glucose sensor, ostomy bag, etc.)		
25. Wear a hearing air or cochlear implant?		
26. Wear protective eyewear, such as goggles or a face shield?		
FAMILY HEART HEALTH HISTORY	**YES**	**NO**
27. Have any relative who's been diagnosed with: [If Yes, check all that apply] ☐Enlarged heart/Hypertrophic or Dilated Cardiomyopathy ☐Arrhythmogenic Right Ventricular Cardiomyopathy ☐Heart Rhythm problems, long or short QT interval ☐Brugada Syndrome ☐Catecholaminergic Ventricular Tachycardia ☐Marfan Syndrome (aortic rupture) ☐Heart attack at age 50 or younger ☐Pacemaker or implanted cardiac defibrillator		
28. A family history of: [If Yes, check all that apply] ☐Known heart abnormalities or sudden death before age 50 ☐Unexplained fainting, seizures, drowning, near drowning or car accident before age 50 ☐Structural heart abnormality, repaired or unrepaired		

Student Name:	DOB:

Has/Does your child:		
HEART HEALTH	**YES**	**NO**
29. Ever complained of light headedness or dizziness during or after exercise?		
30. Ever complained of chest pain, tightness or pressure during or after exercise?		
31. Ever complained of fluttering in their chest, skipped heartbeats, or heart racing?		
32. Ever had a test by a health care provider for his/her heart (e.g. EKG, echocardiogram, stress test)?		
33. Ever been told by a health care provider he/she has a heart or blood vessel problem? If so, check all that apply: ☐Heart infection ☐Heart Murmur ☐Pacemaker ☐High Blood Pressure ☐Low Blood Pressure ☐High Cholesterol ☐Kawasaki Disease ☐Chest pain/tightness ☐New fast or slow heart rate ☐Implanted cardiac defibrillator ☐Other: _____	☐	☐
COVID-19 Information	**YES**	**NO**
34. Has your child ever tested positive for COVID-19?		
If **NO**, **STOP**. If **YES**, answer questions below:		
Date of positive COVID test: _____		
Was your child symptomatic?		
Did your child see a health care provider for their COVID-19 symptoms?		
Was your child hospitalized for COVID-19?		
Was your child diagnosed with Multisystem Inflammatory Syndrome?		

Has/Does your child:		
INJURY HISTORY	**YES**	**NO**
35. Ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling?		
36. Ever been diagnosed with a stress fracture?		
37. Ever had an injury, pain, or swelling of joint that caused him/her to miss practice or a game?		
38. Have a bone, muscle, or joint injury that bothers him/her?		
39. Have joints become painful, swollen, warm, or red with use?		
SKIN HEALTH	**YES**	**NO**
40. Currently have any rashes, pressure sores, or other skin problems?		
41. Ever had a herpes or MRSA skin infection?		
DIGESTIVE (GI) HEALTH	**YES**	**NO**
42. Have a special diet or need to avoid certain foods?		
43. Have concerns about his/her weight?		
44. Have stomach or other GI problems?		
45. Ever had an eating disorder?		
FEMALES Only	**YES**	**NO**
Begun regular menstruation? If YES, age periods began: _____		
MALES Only	**YES**	**NO**
Have only one testicle?		
Have groin pain or a bulge, or a hernia?		

***** Please EXPLAIN fully any question you answered "YES" to in the space below. *****

(Please print clearly & provide specifics and dates if known. Include any health history not listed. Attach additional sheet if needed.)

_____

_____

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There is a risk of injury that is inherent in all sports, which may be severe. I understand that the School District does not provide student accident insurance for participants in interscholastic athletics and that it is my responsibility to assume any cost resulting from athletic injuries. I agree to hold the District harmless for any such injury to my child. I also give permission for emergency transport and/or emergency treatment in the event of injury incurred in connection with said sport.
I agree to assume financial responsibility for any equipment issued to the student in case of loss or damage.

Parent/Guardian Signature:_____ Date: _____