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 Concerns	**Yes**	**No**
1. Ever been restricted by a doctor, physician assistant, or nurse practitioner from sports participation for any reason?		
2. Have an ongoing medical condition? ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Sickle Cell trait ☐ Other or disease		
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. Carry an epinephrine auto-injector?		
Breathing (Respiratory) Health	**Yes**	**No**
13. Ever complained of getting more tired or short of breath than his/her friends during exercise?		
14. Wheeze or cough frequently during or after exercise?		
15. Ever been told by their health care provider they have asthma?		

Has/Does your child:		
Breathing (Respiratory) Health *continued*	**Yes**	**No**
16. Use or carry an inhaler or nebulizer?		
Concussion/ Head Injury History	**Yes**	**No**
17. Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told he/she had a concussion?		
18. Have you ever had a head injury or concussion?		
19. Ever had headaches with exercise?		
20. Ever had any unexplained seizures?		
21. Currently receive treatment for a seizure disorder or epilepsy?		
Devices/Accommodations	**Yes**	**No**
22. Use a brace, orthotic, or other device?		
23. Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)? If yes there may be need for another required form to be filled out.		
24. Wear protective eyewear, such as goggles or a face shield?		
Family History	**Yes**	**No**
25. Have any relative who's been diagnosed with a heart condition, such as a murmur, developed hypertrophic cardiomyopathy, Marfan Syndrome, Brugada Syndrome, right ventricular cardiomyopathy, long QT or short QT syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
FEMALES Only	**Yes**	**No**
26. Begun having her period? If yes, age periods began: _____		
MALES Only	**Yes**	**No**
27. Have only one testicle?		
28. Have groin pain or a bulge or hernia in the groin?		

Student Name:	DOB:

Has/Does your child:		
Heart Health	**Yes**	**No**
29. Ever passed out during or after exercise?		
30. Ever complained of light headedness or dizziness during or after exercise?		
31. Ever complained of chest pain, tightness or pressure during or after exercise?		
32. Ever complained of fluttering in their chest, skipped beats, or their heart racing, or does he/she have a pacemaker?		
33. Ever had a test by their medical provider for his/her heart (e.g. EKG, echocardiogram stress test)?		
34. Ever been told they have a heart condition/problem by a physician? ☐ ☐ If so, check all that apply: ☐Heart infection ☐Heart Murmur ☐High Blood Pressure ☐Low Blood Pressure ☐High Cholesterol ☐Kawasaki Disease ☐Other:		
Injury History	**Yes**	**No**
35. Ever been diagnosed with a stress fracture?		

Has/Does your child:		
Injury History *continued*	**Yes**	**No**
36. Ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling?		
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. Have had a herpes or MRSA skin infections?		
Stomach Health	**Yes**	**No**
42. Ever become ill while exercising in hot weather?		
43. Have a special diet or have to avoid certain foods?		
44. Have to worry about his/her weight?		
45. Have stomach problems?		
46. Have you ever had an eating disorder?		

COVID-19 Information	**No**	**Yes**
47. Has your child ever tested positive for COVID-19?		
48. Was your child symptomatic?		
49. Did your child see a healthcare provider (HCP) for their COVID-19 symptoms?		
50. Did your child have any cardiac symptoms (new fast or slow heart rate, chest tightness or pain, blood pressure changes, or HCP diagnosed cardiac condition)? If yes, please provide additional information.		
51. Was your child hospitalized? If yes, provide date(s)? _____		
If yes, was your child diagnosed with Multisystem Inflammatory syndrome (MISC)?		
If yes, is your child under a HCP's care for this?		

***Please explain fully any question you answered "Yes" to in the space below.** (Please print clearly and provide specifics and dates if known. Also include any health history not listed above. Attach additional sheet if necessary.)

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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: _____