DOLGEVILLE CENTRAL SCHOOL
INTERVAL HEALTH HISTORY FOR ATHLETICS

Student Name:	DOB:
School Name: Dolgeville Central School	Age:

Grade (check): ❑ 7 ❑ 8 ❑ 9 ❑ 10 ❑ 11 ❑ 12	Level (check): ❑ Modified ❑ JV ❑ Varsity
Sport:	Limitations: ❑ Yes ❑ No
Date of last health exam:	Date form completed:

MUST BE COMPLETED BY PARENT/GUARDIAN, PROVIDE DETAILS TO ANY YES ANSWERS ON THE LAST PAGE.
Medicines needed at practice and/or athletic event require the proper paperwork. Contact the school with questions.

DOES OR HAS YOUR CHILD:

GENERAL HEALTH	No	Yes
Ever been restricted by a health care provider from sports participation for any reason?	❑	❑
Ever had surgery?	❑	❑
Ever spent the night in a hospital?	❑	❑
Been diagnosed with mononucleosis within the last month?	❑	❑
Have only one functioning kidney?	❑	❑
Have a bleeding disorder?	❑	❑
Have any problems with hearing or have congenital deafness?	❑	❑
Have any problems with vision or only have vision in one eye?	❑	❑
Have an ongoing medical condition? If yes, check all that apply: ❑ Asthma ❑ Diabetes ❑ Seizures ❑ Sickle Cell trait or disease ❑ Other:		
Have Allergies? ❑ ❑ If yes, check all that apply: ❑ Food ❑ Insect Bite ❑ Latex ❑Medicine ❑ Pollen ❑ Other		
Ever had anaphylaxis?	❑	❑
Carry an epinephrine auto-injector?	❑	❑

BRAIN / HEAD INJURY HISTORY	No	Yes
Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told they had a concussion?	❑	❑
Receive treatment for a seizure disorder or epilepsy?	❑	❑
Ever had headaches with exercise?	❑	❑
Ever had migraines?	❑	❑

DOES OR HAS YOUR CHILD:

BREATHING	No	Yes
Ever complained of getting extremely tired or short of breath during exercise?	❑	❑
Use or carry an inhaler or nebulizer?	❑	❑
Wheeze or cough frequently during or after exercise?	❑	❑
Ever been told by a health care provider they have asthma or exercise-induced asthma?	❑	❑

DEVICES / ACCOMMODATIONS	No	Yes
Use a brace, orthotic, or another device?	❑	❑
Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)?	❑	❑
Wear protective eyewear, such as goggles or a face shield?	❑	❑
Wear a hearing aid or cochlear implant?	❑	❑

Let the coach/school nurse know of any device used. Not required for contact lenses or eyeglasses.

DIGESTIVE (GI) HEALTH	No	Yes
Have stomach or other GI problems?	❑	❑
Ever had an eating disorder?	❑	❑
Have a special diet or need to avoid certain foods?	❑	❑
Are there any concerns about your child's weight?	❑	❑

INJURY HISTORY	No	Yes
Ever been unable to move their arms or legs or had tingling, numbness, or weakness after being hit or falling?	❑	❑
Ever had an injury, pain, or swelling of a joint that caused them to miss practice or a game?	❑	❑
Have a bone, muscle, or joint that bothers them?	❑	❑
Have joints that become painful, swollen, warm, or red with use?	❑	❑
Ever been diagnosed with a stress fracture?	❑	❑

Student Name:	DOB:

DOES OR HAS YOUR CHILD:		
HEART HEALTH	No	Yes
Ever complained of:		
Ever had a test by a health care provider for their heart (e.g., EKG, echocardiogram, stress test)?	❑	❑
Lightheadedness, dizziness, during or after exercise?	❑	❑
Chest pain, tightness, or pressure during or after exercise?	❑	❑
Fluttering in the chest, skipped heartbeats, heart racing?	❑	❑
Ever been told by a health care provider they have or had a heart or blood vessel problem?	❑	❑

If yes, check all that apply:

- ❑ Chest Tightness or Pain
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ New fast or slow heart rate
- ❑ Heart Infection
- ❑ Heart Murmur
- ❑ Low Blood Pressure
- ❑ Kawasaki Disease
- ❑ Has implanted cardiac defibrillator (ICD)
- ❑ Has a pacemaker
- ❑ Other:

DOES OR HAS YOUR CHILD:		
FEMALES ONLY	No	Yes
Have regular periods?	❑	❑
MALES ONLY	No	Yes
Have only one testicle?	❑	❑
Have groin pain or a bulge, or a hernia?	❑	❑
SKIN HEALTH	No	Yes
Currently have any rashes, pressure sores, or other skin problems?	❑	❑
Ever had a herpes or MRSA skin infection?	❑	❑
COVID-19 INFORMATION	No	Yes
Has your child ever tested positive for COVID-19?	❑	❑
If **NO, STOP.** Go to Family Heart Health History. 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?	❑	❑
Was your child diagnosed with Multisystem Inflammatory Syndrome (MISC)?	❑	❑

FAMILY HEART HEALTH HISTORY

A relative has/had any of the following:
Check all that apply:

- ❑ Enlarged Heart/ Hypertrophic Cardiomyopathy/ 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 (ICD)?

A family history of:

- ❑ Known heart abnormalities or sudden death before age 50?
- ❑ Structural heart abnormality, repaired or unrepaired?
- ❑ Unexplained fainting, seizures, drowning, near drowning, or car accident before age 50?

If you answered **NO** to ***all*** questions, **STOP**. Sign and date below.
GO to page 3 if you answered **YES** to a question.

Parent/Guardian Signature: _____ Date: _____

Student Name:	DOB:

If you answered **YES** to any questions give details. Sign and date below**.**

Parent/Guardian Signature: _____ Date: _____