Student Name: _____

BARKER CENTRAL SCHOOL
HEALTH HISTORY FOR SPORTS PARTICIPATION

Prior to the start of **tryout sessions** or **practice** at the beginning of each season, a health history review for each athlete must be completed. Students are not eligible to participate in practice or tryouts until approved by the school doctor.

PART A – TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE

Student: _____ Age: _____

Grade: _____

Sport: _____ Date of Birth: _____

Date of last health physical: _____

Please note: This information is for the nurse and student's health record only. Only pertinent information such as allergies, asthma, and chronic health concerns will be forwarded to the coach, unless otherwise directed below. Signing this form gives consent for nurse to share the above with the coach.

PART B- To Be Completed by the Parent

QUESTION	YES	NO	IF YES, PLEASE DESCRIBE
Ever been restricted by a doctor or nurse practitioner from sports participation for any reason?	☐	☐	
Have an ongoing medical condition? Please circle: Asthma Diabetes Seizures Sickle Cell trait or disease Other	☐	☐	
Ever had surgery?	☐	☐	
Ever spent the night in a hospital?	☐	☐	
Have a life threatening allergy? Please circle: Medication Food Insect Bites Pollen Latex Other	☐	☐	
Carry an epinephrine auto injector?	☐	☐	
Ever passed out during or after exercise?	☐	☐	
Ever complained of light headedness or dizziness during or after exercise?	☐	☐	
Ever complained of chest pain, tightness or pressure during or after exercise?	☐	☐	
Ever complained of fluttering in their chest, skipped beats, or their heart racing, or does s/he have a pacemaker?	☐	☐	
Has your child ever had a test for his/her heart? (eg. EKG, echocardiogram, stress test)	☐	☐	
Ever been told they have a heart condition or problem?	☐	☐	
Ever had high or low blood pressure?	☐	☐	

QUESTION	YES	NO	IF YES, PLEASE DESCRIBE
Ever complained of getting more tired or short of breath than his/her friends during exercise?	☐	☐	
Wheeze or cough frequently during or after exercise?	☐	☐	
Ever been told by their health care provider they have asthma?	☐	☐	
Use or carry an inhaler or nebulizer?	☐	☐	
Ever become ill while exercising in hot weather?	☐	☐	
Have to worry about their weight?	☐	☐	
Have stomach problems?	☐	☐	
Ever had a hit to the head that caused a headache, dizziness, nausea, or confusion, or ever been told s/he had concussion?	☐	☐	
Ever have headaches with exercise?	☐	☐	
Ever had a seizure?	☐	☐	
Ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling?	☐	☐	
Ever had any joint pain, ligament tear, or a muscle pull?	☐	☐	
Use a brace, orthotic, or other device?	☐	☐	
Have any problems with his/her hearing or wear hearing aids?	☐	☐	
Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)?	☐	☐	
Have any problems with his/her vision or have vision in one eye only?	☐	☐	
Wear glasses or contacts?	☐	☐	
Ever had a hernia?	☐	☐	
Does s/he have only 1 functioning kidney?	☐	☐	

QUESTION	YES	NO	IF YES, PLEASE DESCRIBE
Ever had an injury to the spleen?	☐	☐	
Does s/he have a bleeding disorder?	☐	☐	
Females Only	**YES**	**NO**	**IF YES, PLEASE DESCRIBE**
Has she had her period?	☐	☐	
Males Only	**YES**	**NO**	**IF YES, PLEASE DESCRIBE**
Does he only have one testicle?	☐	☐	
Family History	**YES**	**NO**	**IF YES, PLEASE DESCRIBE**
Has any relative ever been diagnosed with a heart condition or developed hypertrophic cardiomyopathy, Marfan Syndrome, right cardiomyopathy, long QT or short QT syndrome or VT?	☐	☐	
Has any relative died suddenly before the age of 50 from unknown or heart related causes?	☐	☐	

Please use this space if needed for additional comments/pertinent health information.

_____

_____

_____

_____

_____

PART C – <u>PARENTAL PERMISSION</u>

I, the undersigned, clearly understand these questions are asked in order to decide if my child can safely participate on the athletic team named in PART A of this form. The answers are correct as of this date and he/she has my permission to participate.

SIGNED: _____ DATE: _____

PLEASE RETURN THIS COMPLETED FORM TO THE HEALTH OFFICE

Office use: _____

Date received: _____

Approved by: _____

PERMISSION FOR EMERGENCY MEDICAL TREATMENT

In the event of an emergency requiring medical attention, every effort will be made to contact the parent or guardian in order to receive authorization before any treatment or hospitalization is undertaken.

I hereby grant permission for a physician or hospital personnel designated by the Barker Central School District to attend my son or daughter.

Student's Name _____

Parent's Signature _____

Date _____ Home Phone _____

Business Phone _____

Cell Phone _____

1. Emergency Contact _____

Phone _____

2. Emergency Contact _____

Phone _____

Coaches are to keep this sheet on person through the duration of the season.

Office use: _____

Date received: _____

Approved by: _____