INTERVAL HEALTH HISTORY SINCE LAST SPORTS PHYSICAL FOR SPORTS PARTICIPATION

Part A: To be completed by the Student

Name_____ Age_____

Grade_____ Date of Birth_____

Sport_____

For office use only

CF _____Mat_____ Last phys._____

Med OK _____

Needs: _____

Part B: History SINCE LAST SPORT PHYSICAL to be completed by Parent/Guardian

Note: "Yes" to any of these questions does not mean automatic disqualification from the athletic activity indicated in Part A above. However, it will require a review and approval by the school physician before the student can report to practice or tryouts. The answers to the questions on this form will be held in the school health office and will be kept confidential.

		Check	
1.	Any injuries requiring medical attention?	☐Yes	☐No
2.	Any head injury/concussion?	☐Yes	☐No
3.	Any illness lasting more than five (5) days?	☐Yes	☐No
4.	Any condition causing student to miss game/practice?	☐Yes	☐No
5.	Taking medicine or under physician's care at this time?	☐Yes	☐No
6.	Any feeling of faintness, dizziness or fatigue after exercise or exertion?	☐Yes	☐No
7.	Any surgical operations/fractures?	☐Yes	☐No
8.	Any treatment in a hospital or emergency room?	☐Yes	☐No
9.	Developed any allergies?	☐Yes	☐No
10.	Diagnosed with chronic disease?	☐Yes	☐No
11.	Does your child need an Inhaler or Epi-pen in school/sports?	☐Yes	☐No

If "yes" to any of these questions, please explain_____

Part C: Parental Permission

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.

_____ _____

Signature Date rev. 1/13