SPORTS CANDIDATES QUESTIONNAIRE AND HEALTH HISTORY

***Parent/Guardian must complete this form and submit it to the student's current Health Office.**
*** A copy of student's physical (within 12 months of first practice date) must be provided or already on file.**

Part A: Please print	**For Health Office use only:**
Student's Name:________________________	Med OK______ FID_______ APP______
Grade:_______ Age:________ DOB: _______	Allergies/Limitations:____________________
SPORT:_______________________________	Hx of COVID-19______ Cardiac Eval._____
Varsity_____ Jr. Varsity_____ Modified______	Date of last physical______________

Part B: HEALTH HISTORY TO BE COMPLETED BY PARENT/GUARDIAN IN INK.

Has your child ever tested positive for COVID-19? _______
Was your child symptomatic? _______ If yes number of days?______
Was your child hospitalized for COVID-19 symptoms?_____________________________________
Did your child have any cardiac symptoms? If yes, please provide additional information________________
____
Was your child diagnosed with Multisystem Inflammatory syndrome (MISC)? ________

Has your child ever had: (please check)	**Yes**	**No**		**Yes**	**No**
Allergies-Food, drug, other	☐	☐	Heart Problems	☐	☐
-requires Epi-Pen or Benadryl	☐	☐	Family History of Sudden Death	☐	☐
Asthma	☐	☐	< 50 years of age	☐	☐
-requires inhaler for school/sports	☐	☐	Joint/Ligament/Muscle Injury	☐	☐
Anemia	☐	☐	Fracture/Dislocation Bone or Joint	☐	☐
Bladder/Kidney problem	☐	☐	Arthritis	☐	☐
Single Kidney	☐	☐	Neck Injury	☐	☐
Diabetes	☐	☐	Back/Pain Injury	☐	☐
Ear Problems/Hearing loss	☐	☐	Nose Bleeds-Frequent	☐	☐
Eye Problems/Vision loss	☐	☐	Recent Weight Gain/Loss	☐	☐
-one eye/ contact lenses	☐	☐	Eating Disorder	☐	☐
Stomach/Intestinal problems	☐	☐	Under Medical Care now?	☐	☐
Dental Problems/ Orthodontics	☐	☐	On any medication now?	☐	☐
High Blood Pressure	☐	☐	Treated in the hospital/ER in the past year?	☐	☐
Chest Pain	☐	☐	Had prolonged illness in past year?	☐	☐
Headaches	☐	☐	**Females Only:**		
Seizures	☐	☐	Missed >3menstral periods in a row	☐	☐
Fainting Episodes	☐	☐	**Males Only:**		
Head Injury/Concussion			Hernia/Varicocele	☐	☐
-if yes, how many________			Single Testicle	☐	☐

IF YES TO ANY OF THE ABOVE QUESTIONS, PLEASE EXPLAIN & ADD DATES:

____
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I agree with the above answers and consent to participation of my child in the interscholastic program of Starpoint including practice sessions and travel to and from athletic contests. I also agree to emergency medical treatment as deemed necessary by the physicians designated by school authorities.

Parent/Guardian Signature _____________________ Date _________ School MD Sig_________________ Date_______

High School Nurse's Fax 210-2361 Middle School Nurse's Fax 210-2231