Gilbertsville-Mount Upton Central School
693 State Highway 51
Gilbertsville, New York 13776

INTERVAL 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 conducted unless the student received a full medical examination within 30 days of the start of the season.

PART A: TO BE COMPLETED BY THE PARENT **Date: _____**

Student: _____ **Age: _____**

Grade (check): ___ 7 ___ 8 ___ 9 ___ 10 ___ 11 ___ 12 **Date of Birth: _____**

Sport: _____ **Level (check): ___ Varsity ___ JV ___ Modified**

Date of last health exam: ___/___/_____ **Limitations: _____ Yes _____ No**

PART B: MUST BE COMPLETED AND SIGNED 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.

HISTORY SINCE LAST HEALTH APPRAISAL:

If the answer to any of the following questions is "YES" in PART C on the reverse side of this form, please describe the condition or situation that prompted your answer.

1. Any injuries requiring medical attention?	**___ NO**	**___ YES**
2. Any illness lasting more than five (5) days?	**___ NO**	**___ YES**
3. Taking medicine or under physician's care at this time?	**___ NO**	**___ YES**
4. Any feeling of faintness, dizziness or fatigue after exercise or exertion?	**___ NO**	**___ YES**
5. Change in wearing glasses or contact lens?	**___ NO**	**___ YES**
6. Any surgical operations or fractures?	**___ NO**	**___ YES**
7. Any treatment in a hospital or emergency room?	**___ NO**	**___ YES**
8. Developed any allergies?	**___ NO**	**___ YES**
9. Any chronic disease?	**___ NO**	**___ YES**

Student Name:		Date of Birth:	

Part B: Interval Health History (Continued)

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 vision or only have vision in one eye?	☐	☐
Have any problems with hearing or have congenital deafness?	☐	☐
Have an ongoing medical condition? If yes, check all that apply: ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Sickle Cell Trait ☐ 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 and 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/ACCOMODATIONS	NO	YES
Use a brace, orthotic, or another device?	☐	☐
Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)?	☐	☐
Wear protective eye wear, such as googles or a face shield?	☐	☐
Wear a hearing aid or cochlear implant?	☐	☐
Let the coach/school nurse know of any devices 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:		Date of Birth:	

Part B: Interval Health History (Continued)

DOES OR HAS YOUR CHILD		
HEART HEALTH	NO	YES
Ever had a test by a health care provider for their heart (e.g., EKG, echocardiogram, stress test)?	☐	☐
Ever complained of lightheadedness, dizziness, during or after exercise?	☐	☐
Ever complained of chest pain, tightness, or pressure during or after exercise?	☐	☐
Ever complained of fluttering in the chest, skipped heart beats, 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 ☐ Heart Infection ☐ Heart Murmur ☐ High Blood Pressure ☐ High Cholesterol ☐ Low Blood Pressure ☐ New Fast or Slow Heart Rate ☐ 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 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 Health History. If **YES,** answer the 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
☐ Pacemaker or implanted cardiac defibrillator (ICD)
☐ Brugada Syndrome
☐ Catecholaminergic Ventricular Tachycardia
☐ Marfan Syndrome (aortic rupture)
☐ Heart attack at age 50 or younger

A family history of:

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

If you answered **NO** to **all** questions, **STOP.** Sign & Date below.
GO to next page if you answered **YES** to a question & provide more details.

Parent/Guardian Signature:	Date:

Student Name:		Date of Birth:	

Part C: Interval Health History (More Information)

If you answered **YES** to any questions, please provide more details. **Sign & Date below.**	
Parent/Guardian Signature:	Date:

Part D: 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.

Signed: _____ **Date:** _____

Part E: Concussion Information & Sudden Cardiac Arrest Information

NYSED & NYS Department of Health post information relating to mild trauma brain injuries on their websites. Attached is a "Student & Parent Information Form" and a "Fact Sheet for Parents"

The Dominic Murray Sudden Cardiac Arrest Prevention Act is a new law as of July 1, 2022.
This law requires schools, students, and parents/guardians have information on sudden cardiac arrest risks, signs, and symptoms. Attached is an information document on Sudden Cardiac Arrest that includes risks, signs, and symptoms.

Parental Acknowledgement:
I have received the Concussion Education Information & Sudden Cardiac Arrest Information (as listed above)

Signed: _____ Date: _____

PLEASE RETURN TO THE SCHOOL HEALTH OFFICE

To be completed by the school health office

Sports Participation: _____ Approved _____ Referred to the School Physician

Signed: _____ Date: _____
(School Health Office)

If referred to the School Physician: _____ Re-Qualified _____ Disqualified

Signed: _____ Date: _____
(School Physician)