INTERVAL HEALTH HISTORY FOR SPORTS PARTICIPATION

Laurens Central School
55 Main St.
Laurens, NY 13796
(607) 432-2050

DATE:_____

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 STUDENT AND PARENT

Student:_____ Age:_____

Grade(check): o elementary o 7 o 8 o 9 o 10 o 11 o 12 Date of Birth: ____/____/____

Sport:_____ Level (check): o Varsity o JV o Modified o color guard (mixed)

Date of last health appraisal: _____/_____/_____ ***(NOTE; COPY MUST BE ON FILE IN NURSE'S OFFICE)***
Limitations: o Yes oNo

PART B: TO BE COMPLETED BY THE PARENT OR 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,

1.	Any injuries requiring medical attention?	o Yes oNo
2.	Any illness lasting more than five (5) days?	o Yes oNo
3.	Taking medicine or under physician's care at this time?	o Yes oNo
4.	Any feeling of faintness, dizziness or fatigue after exercise or exertion?	o Yes oNo
5.	Change in wearing glasses or contact lenses?	o Yes oNo
6.	Any surgical operations or fractures?	o Yes oNo
7.	Any treatment in a hospital or emergency room?	o Yes oNo
8.	Developed any allergies?	o Yes oNo
9.	Any chronic disease?	o Yes oNo

PART C: TO BE COMPLETED BY PARENT OR GUARDIAN

Describe the condition or situation that caused any questions in PART B to be answered "YES".

_____

_____

_____

_____

_____

_____

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: ____/____/____

PLEASE RETURN TO THE SCHOOL HEALTH OFFICE BEFORE THE BEGINNING OF PRACTICE

PART E: TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE

Sports Participation:

o Approved o Referred to School Physician

Signed:_____ Date:____/____/____
School Health Office

If referred to the School Physician:

o Requalified o Disqualified

Signed:_____ Date:____/____/____
School Physician