Laurens Central School Athletic Interval Health History

Student Name:			DOB:		
Sport:			Age:		
Level: circle one Modified JV Varsity					
Date of last physical:			Today's Date:		

Must be completed by parent or guardian - give details to any "yes" answer on the last page.

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 hearing or have congenital deafness?	☐	☐
Have any problems with vision or only have vision in one eye?	☐	☐
Have any of the ongoing medical conditions: Circle all that apply Asthma Diabetes Seizures Sickle cell trait other:	☐	☐
Have allergies? Circle 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, or been told they had a concussion?	☐	☐
Receive treatment for a seizure disorder or epilepsy?	☐	☐
Ever had headaches w/ 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 an inhaler or nebulizer	☐	☐
Cough frequently during or after exercise?	☐	☐
Ever been told by a health care provider they have asthma?	☐	☐

DEVICES /ACCOMMODATIONS	NO	YES
Use a brace, orthotic, etc.	☐	☐
Have any special devices or prostheses (insulin pump, etc.)	☐	☐
Wear protective eyewear, such as goggles or a face shield?	☐	☐
Wear a hearing aid or implant?	☐	☐
LET THE COACH/SCHOOL NURSE KNOW OF ANY DEVICE USED. Not required for lenses or glasses.		

DIGESTIVE HEALTH	NO	YES
Are there any concerns with your child's weight?	☐	☐
Have stomach or GI problems?	☐	☐

INJURY HISTORY	NO	YES
Ever been diagnosed with a stress fracture?	☐	☐
Ever been unable to move their arms or legs or had tingling or weakness after being hit or falling?	☐	☐
Have a bone, muscle, or joint that bothers them?	☐	☐

Student Name:	**DOB:**

DOES OR HAS YOUR CHILD:

HEART HEALTH	NO	YES
Ever had a test by a health care provider for their heart?	☐	☐
Light headedness, dizziness during exercise?	☐	☐
Chest Pain, tightness, opr pressure during or after exercise?	☐	☐
Fluttering in the chest, skipped heartbeats, heart racing?	☐	☐
Ever been told by a health care provider they have or had a heart or blood vessel problem? (check all that apply)	☐	☐

chest tightness/pain heart infection

High blood pressure heart murmur

high cholesterol low blood pressure

New fast/slow heart rate

Has implanted cardiac defibrillator

has a pace maker Kawasaki disease

Other:

A Family History of: circle all that apply

Known heart abnormalities or sudden death under 50

Structural heart abnormality, repaired or unrepaired

Unexplained fainting, seizures, etc. prior to age 50

DOES OR HAS YOUR CHILD:

COVID-19 INFORMATION	NO	YES
Has your child ever tested positive for Covid-19? If NO, STOP. Go to family heart health history , If YES, answer questions below:	☐	☐
	☐	☐
Date of positive Covid Test	☐	☐
Was your child symptomatic?	☐	☐
Did your child see a healthcare provider for the covid-19 symptoms?	☐	☐
Was your child hospitalized for Covid?	☐	☐
Was your child diagnosed with Multisystem inflammatory Syndrome (MISC)?	☐	☐

Family heart health history

Relative has had any of the following (circle all that apply):

Enlarged heart/cardiomyopathy

Arrhythmogenic right ventricular cardiomyopathy

Heart rhythm problems, long or short QT interval

Brugada Syndrome

Catecholaminergic ventricular tachycardia

Marfan Syndrome (aortic rupture)?

Heart attack at age 50 of younger?

Pacemaker or implanted cardiac defibrillator

If you answered NO to all questions, STOP. Sign and date below.

Go to next page if you answered yes to any question.

Parent/Guardian Signature:	Date:

Student Name:	**DOB:**

If you answered yes to any questions give details below.
Parent/Guardian Signature: Date: