DOMINICAN ACADEMY
Catholic College Preparatory School for Girls

Interval Health History for Athletics – Both pages must be completed.	
Student Name:	DOB:
Grade (check): ☐9 ☐10 ☐11 ☐12	
Sport:	Limitations: ☐ Yes ☐ No
Date of last health exam:	

Health History to Be Completed by Parent/Guardian, Provide Details to Any Yes Answers on Back.
Medicines needed at practice and/or athletic event require the proper paperwork, contact school with questions.

Has/Does your child:		
General Health Concerns	**No**	**Yes**
1. Ever been restricted by a health care provider from sports participation for any reason?		
2. Have an ongoing medical condition? ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Sickle Cell trait or disease ☐ Other		
3. Ever had surgery?		
4. Ever spent the night in a hospital?		
5. Been diagnosed with Mononucleosis within the last month?		
6. Have only one functioning kidney?		
7. Have a bleeding disorder?		
8. Have any problems with hearing or wears hearing aid(s)?		
9. Have any problems with vision or has vision in only one eye?		
10. Wear glasses or contacts?		
Allergies		
11. Have a life-threatening allergy? Check any that apply: ☐ Food ☐ Insect Bite ☐ Latex ☐ Medicine ☐ Pollen ☐ Other		
12. Carry an epinephrine auto-injector?		
Breathing (Respiratory) Health	**No**	**Yes**
13. Ever complained of getting more tired or short of breath than their friends during exercise?		
14. Wheeze or cough frequently during or after exercise?		
15. Ever been told by a health care provider they have asthma?		
16. Use or carry an inhaler or nebulizer?		

Has/Does your child:		
Concussion/ Head Injury History	**No**	**Yes**
17. Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told they had a concussion?		
18. Ever had a head injury or concussion?		
19. Ever had headaches with exercise?		
20. Ever had any unexplained seizures?		
21. Currently receive treatment for a seizure disorder or epilepsy?		
Devices/Accommodations	**No**	**Yes**
22. Use a brace, orthotic, or other device?		
23. Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)? If yes, there may be need for another required form to be filled out.		
24. Wear protective eyewear, such as goggles or a face shield?		
Family History	**No**	**Yes**
25. Have any relative who's been diagnosed with a heart condition?		
Has your child:	**No**	**Yes**
26. Begun having her period?		
27. Age periods began:		
28. Have regular periods?		
29. Date of last menstrual period:		

Interval Health History for Athletics – P a g e 2

Student Name:	DOB:

Has/Does your child:

Heart Health	**No**	**Yes**
32. Ever passed out during or after exercise?		
33. Ever complained of light headedness or dizziness during or after exercise?		
34. Ever complained of chest pain, tightness or pressure during or after exercise?		
35. Ever complained of fluttering in their chest, skipped beats, or their heart racing, or does your child have a pacemaker?		
36. Ever had a heart test by a health care provider (e.g. EKG, echocardiogram stress test)?		
37. Ever been told they have a heart condition or problem by a health care provider? If so, check all that apply: ☐Heart infection ☐Heart Murmur ☐High Blood Pressure ☐Low Blood Pressure ☐High Cholesterol ☐Kawasaki Disease ☐Other:		
Injury History	**No**	**Yes**
38. Ever been diagnosed with a stress fracture?		

Has/Does your child:

Injury History continued	**No**	**Yes**
39. Ever been unable to move their arms and legs, or had tingling, numbness, or weakness after being hit or falling?		
40. Ever had an injury, pain, or swelling of joint that caused them to miss practice or a game?		
41. Have a bone, muscle, or joint injury that bothers them?		
42. Have joints become painful, swollen, warm, or red with use?		
Skin Health	**No**	**Yes**
43. Currently have any rashes, pressure sores, or other skin problems?		
44. Have had a herpes or MRSA skin infections?		
Stomach Health	**No**	**Yes**
45. Ever become ill while exercising in hot weather?		
46. Have a special diet or need to avoid certain foods?		
47. Have to worry about their weight		
48. Have stomach problems?		
49. Ever had an eating disorder?		

COVID-19 Information	**No**	**Yes**
50. Has your child ever tested positive for COVID-19?		
51. Was your child symptomatic?		
52. Did your child see a healthcare provider (HCP) for their COVID-19 symptoms?		
53. Did your child have any cardiac symptoms (new fast or slow heart rate, chest tightness or pain, blood pressure changes, or HCP diagnosed cardiac condition)? If yes, please provide additional information.		
54. Was your child hospitalized? If yes, provide date(s)?		
If yes, was your child diagnosed with Multisystem Inflammatory syndrome (MISC)?		
If yes, is your child under a HCP's care for this?		

Please explain fully any question you answered yes to in the space below, include dates if known. Use additional pages if necessary.

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Parent/Guardian Signature: ____________________________ Date: ________________