NYSED Interval Health History for Athletics

Student Name:	DOB:
Grade (check): ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12	Sport:
Sport Level: ☐ Modified ☐ Fresh ☐ JV ☐ Varsity	Date of last physical:

MUST be completed and signed by Parent/Guardian - Give details to any YES answers on the last page.

GENERAL HEALTH	NO	YES
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 an ongoing medical condition?	☐	☐
If yes, check all that apply: ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Sickle cell trait or disease ☐ Other:		
Have Allergies?	☐	☐
If yes, check all that apply ☐ Food ☐ Insect Bite ☐ Latex ☐ Medicine ☐ Pollen ☐ Other:		
Ever had anaphylaxis?	☐	☐
Carry an epinephrine auto-injector?	☐	☐
Ever had an eating disorder?		
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 any unexplained seizures?	☐	☐
Ever had migraines?	☐	☐
INJURY HISTORY	**NO**	**YES**
Ever been unable to move arm/leg or had tingling, numbness, or weakness after being hit or falling?	☐	☐
Have joints become painful, swollen, warm, or red with use?	☐	☐
Been diagnosed with a stress fracture?		
DEVICES / ACCOMMODATIONS	**NO**	**YES**
Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)?	☐	☐
Wear protective eyewear?	☐	☐

BREATHING	☒	☐
Use or carry an inhaler/nebulizer?	☐	☐
Wheeze or cough frequently during or after exercise?	☐	☐
HEART HEALTH		
Ever complained of:		
Ever had a test by a health care provider for their heart (e.g., EKG, echocardiogram, stress test)?	☐	☐
Lightheadedness, dizziness, during or after exercise?	☐	☐
Chest pain, tightness, or 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?	☐	☐
If yes, check all that apply: ☐ Chest Tightness or Pain ☐ Heart infection ☐ High Blood Pressure ☐ Heart Murmur ☐ High Cholesterol ☐ Low Blood Pressure ☐ New fast or slow heart rate ☐ Kawasaki Disease ☐ Has implanted cardiac defibrillator (ICD) ☐ Has a pacemaker ☐ Other:		
FEMALES ONLY	**NO**	**YES**
Have regular periods?	☐	☐
Age period began?		
MALES ONLY	**NO**	**YES**
Have only one testicle?	☐	☐
Have groin pain or a bulge, or a hernia?	☐	☐
COVID-19 INFORMATION		
Has your child ever tested positive for COVID-19?	☐	☐
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?
- ☐ Brugada Syndrome?
- ☐ Catecholaminergic Ventricular Tachycardia?
- ☐ Marfan Syndrome (aortic rupture)?
- ☐ Heart attack at age 50 or younger?
- ☐ Pacemaker or implanted cardiac defibrillator (ICD)?

A family history of:

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

If you answered **NO** to ***all*** questions, **STOP**. Sign and date below.
If you answered **YES** to a question please explain below.

Parent/Guardian Signature:	Date:

If you answered **YES** to any questions give details. Sign and date below**.**

Parent Signature ____ Date ___________________

FOR SCHOOL PHYSICIAN ONLY

This certifies that the above referenced student is physically qualified to participate in the following categories of competition during the school year. Any unmarked categories indicate disqualification for the particular group of sports.

CONTACT/COLLISION ☐	LIMITED CONTACT/IMPACT ☐	NONCONTACT ☐
Cheerleading	Baseball	Cross Country
Football	Volleyball	Track and Field
Ice Hockey	Basketball	Golf
Lacrosse	Softball	Tennis
Soccer		
Wrestling		
Basketball		
Diving/Swim		

School Physician's Signature ____ Date ____________________