

NYSED Interval Health History for Athletics

Student Name:		DOB:
Grade (check): <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12		Limitations: <input type="checkbox"/> NO <input type="checkbox"/> YES
Sport Level: <input type="checkbox"/> Modified <input type="checkbox"/> Fresh <input type="checkbox"/> JV <input type="checkbox"/> 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?	<input type="checkbox"/>	<input type="checkbox"/>
Have only one functioning kidney?	<input type="checkbox"/>	<input type="checkbox"/>
Have a bleeding disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Have any problems with hearing or have congenital deafness?	<input type="checkbox"/>	<input type="checkbox"/>
Have any problems with vision or only have vision in one eye?	<input type="checkbox"/>	<input type="checkbox"/>
Have an ongoing medical condition?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, check all that apply:		
<input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Seizures <input type="checkbox"/> Sickle cell trait or disease <input type="checkbox"/> Other:		
Have Allergies?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, check all that apply		
<input type="checkbox"/> Food <input type="checkbox"/> Insect Bite <input type="checkbox"/> Latex <input type="checkbox"/> Medicine <input type="checkbox"/> Pollen <input type="checkbox"/> Other:		
Ever had anaphylaxis?	<input type="checkbox"/>	<input type="checkbox"/>
Carry an epinephrine auto-injector?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
Receive treatment for a seizure disorder or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had any unexplained seizures?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had migraines?	<input type="checkbox"/>	<input type="checkbox"/>
INJURY HISTORY	No	Yes
Ever been unable to move arm/leg or had tingling, numbness, or weakness after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
Have joints become painful, swollen, warm, or red with use?	<input type="checkbox"/>	<input type="checkbox"/>
Been diagnosed with a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>
DEVICES / ACCOMMODATIONS	No	Yes
Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
Wear protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>

BREATHING	No	Yes
Use or carry an inhaler/nebulizer?	<input type="checkbox"/>	<input type="checkbox"/>
Wheeze or cough frequently during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
HEART HEALTH		
Ever complained of:		
Ever had a test by a health care provider for their heart (e.g., EKG, echocardiogram, stress test)?	<input type="checkbox"/>	<input type="checkbox"/>
Lightheadedness, dizziness, during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain, tightness, or pressure during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Fluttering in the chest, skipped heartbeats, heart racing?	<input type="checkbox"/>	<input type="checkbox"/>
Ever been told by a health care provider they have or had a heart or blood vessel problem?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, check all that apply:		
<input type="checkbox"/> Chest Tightness or Pain <input type="checkbox"/> Heart infection <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Murmur <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> New fast or slow heart rate <input type="checkbox"/> Kawasaki Disease <input type="checkbox"/> Has implanted cardiac defibrillator (ICD) <input type="checkbox"/> Has a pacemaker <input type="checkbox"/> Other:		
FEMALES ONLY	No	Yes
Have regular periods?	<input type="checkbox"/>	<input type="checkbox"/>
Age period began?	<input type="checkbox"/>	<input type="checkbox"/>
MALES ONLY	No	Yes
Have only one testicle?	<input type="checkbox"/>	<input type="checkbox"/>
Have groin pain or a bulge, or a hernia?	<input type="checkbox"/>	<input type="checkbox"/>
COVID-19 INFORMATION		
Has your child ever tested positive for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
Date of positive COVID test:		
Was your child symptomatic?	<input type="checkbox"/>	<input type="checkbox"/>
Did your child see a health care provider for their COVID-19 symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
Was your child hospitalized for COVID?	<input type="checkbox"/>	<input type="checkbox"/>
Was your child diagnosed with Multisystem Inflammatory Syndrome (MISC)?	<input type="checkbox"/>	<input type="checkbox"/>

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

- Cheerleading
- Football
- Ice Hockey
- Lacrosse
- Soccer
- Wrestling
- Basketball
- Diving/Swim

LIMITED CONTACT/IMPACT

- Baseball
- Volleyball
- Basketball
- Softball

NONCONTACT

- Cross Country
- Track and Field
- Golf
- Tennis

School Physician's Signature _____ Date _____