NYSED Interval Health History for Athletics

Student Name:	DOB
School Name:	Age
Grade (check): ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12	Limitations: ☐ NO ☐ YES
Sport	Date of last Health Exam:
Sport Level: ☐ Modified ☐ Fresh ☐ JV ☐ Varsity	Date form completed:
MUST be completed and signed by Parent/Guardian - Give details to any YES answers 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 an ongoing medical conditions?	☐	☐
If yes, check all that apply: ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Sickle cell trait or disease ☐Other:		
Have Allergies?	☐	☐
☐ 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, confusion, or been told they had a concussion?	☐	☐
Receive treatment for a seizure disorder or epilepsy?	☐	☐
Ever had headaches with 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?	☐	☐
Wheeze or cough frequently during or after exercise?	☐	☐
Ever been told by a health care provider they have asthma or exercise-induced asthma?	☐	☐
DEVICES / ACCOMMODATIONS	**NO**	**YES**
Use a brace, orthotic, or anther device?	☐	☐
Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)?	☐	☐
Wear protective eyewear, such as goggles or a face shield?	☐	☐
Wear a hearing aid or cochlear implant?	☐	☐
Let the coach/school nurse know of any device used. Not required for contact lenses or eyeglasses		
DIGESTIVE (GI) HEALTH	**NO**	**YES**
Have stomach or other GI problems?	☐	☐
Ever had an eating disorder?	☐	☐
Have a special diet or need to avoid certain foods?	☐	☐
Are there any concerns about your child's weight?	☐	☐
INJURY HISTORY	**NO**	**YES**
Ever been unable to move their arms or legs or had tingling, numbness, or weakness after being hit or falling?	☐	☐
Ever had an injury, pain or swelling of a joint that caused them to miss practice or a game?	☐	☐
Have a bond, muscle, or joint that bothers them?	☐	☐
Have joints that become painful, swollen, warm or red with use?	☐	☐
Ever been diagnosed with stress fracture?		

DOES OR HAS YOUR CHILD		
HEART HEALTH	**NO**	**YES**
Every 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 the 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:

DOES OR HAS YOUR CHILD		
FEMALES ONLY	**NO**	**YES**
Have regular periods?	☐	☐
MALES ONLY	**NO**	**YES**
Have only on testicle?	☐	☐
Have groin pain or a bulge, or a hernia?	☐	☐
SKIN HEALTH	**NO**	**YES**
Currently have any rashes, pressure sores, or other skin problems?	☐	☐
Ever had a herpes or MRSA skin infection?	☐	☐
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 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 answer **NO** to ***all*** questions, **STOP**, Sign and date below.
If you answered **YES** to any questions give details below then sign and date.

Parent/Guardian Signature:	Date

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