1. Ever been restricted by a health care provider from sports participation for any reason? 1. Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told he/she had a concussion? 1. Ever had a head injury or concussion? 1. Ever had a head injury													
Student Name: School Name:													
Grade (check):		Jilipid	icu.	DOB:									
Sport: Care Check : Modified Fresh JV Varsity	School Name:			Age:									
Sport: Limitations: Yes No Date of last health exam: Date form completed: 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: Has/Does	Grade (check): $\Box 7 \Box 8 \Box 9 \Box 10$	 ☐11	□12										
Date of last health exam: Date form completed:	,												
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the groin?

16. Use or carry an inhaler or nebulizer?

	Sample Recommended N	YSED I	nterva	al He	alth History for Athletics - Page 2	<u> </u>				
Stu	dent Name:									
School Name:				DOB:						
Has/Does your child:				1 [Has/Does your child:					
Hea	rt Health	No	Yes		njury History continued	No	Yes			
	Ever passed out during or after			1 [39. Ever been unable to move his/her arms	110	103	_		
	exercise?				and legs, or had tingling, numbness, or			ı		
33	Ever complained of light headedness or			1	weakness after being hit or falling?	ш	ш			
33.	dizziness during or after exercise?				40. Ever had an injury, pain, or swelling of			_		
3/1	Ever complained of chest pain,	-		1	joint that caused him/her to miss					
34.	tightness or pressure during or after				practice or a game?					
	exercise?	ш	ш		41. Have a bone, muscle, or joint			_		
25	Ever complained of fluttering in their			1	injury that bothers him/her?					
35.	chest, skipped beats, or their heart				42. Have joints become painful, swollen,	$\overline{}$		_		
	racing, or does he/she have a		Ш		warm, or red with use?					
	pacemaker?				Skin Health	No	Yes			
36	Ever had a test by a health care			1 1	43. Currently have any rashes, pressure			_		
30.	provider for his/her heart (e.g. EKG,				sores, or other skin problems?					
	echocardiogram stress test)?		ш		44. Have had a herpes or MRSA skin			_		
27	Ever been told they have a heart condi	tion		1	infections?					
37.	or problem by a health care provider?		ock all		Stomach Health	No	Yes			
		11 30, 61	ieck all	ľ	45. Ever become ill while exercising in hot			_		
that apply: ☐ Heart infection ☐ Heart Murmur				weather?						
	☐ High Blood Pressure ☐ Low Blood P		,		46. Have a special diet or need to avoid			_		
	☐ High Cholesterol ☐ Kawasaki Dis				certain foods?					
	Other:	sease			47. Have to worry about his/her weight	一	\equiv	Γ		
Indian		NIO	Yes	▎▕	48. Have stomach problems?			H		
	ry History	No	res	,		H		H		
38.	Ever been diagnosed with a stress			L	49. Ever had an eating disorder?					
	fracture?									
	/ID-19 Information					No	Yes			
	Has your child ever tested positive for 0	COVID-	19?			\sqcup				
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, pro	ovide d	ate(s)?							
If yes, was your child diagnosed with Multisystem Inflammatory syndrome (MISC)?								Π		
If yes, is your child under a HCP's care for this?										
								_		
	ase explain fully any question you additional pages if necessary.	ı answ	ered y	yes t	o in the space below, include dates if	knov	νn.			
								_		
					.					
Pare	ent/Guardian Signature:				Date:					