

NYSED Interval Health History	
Student Name:	DOB
School Name:	Age
Grade (check): ☐ 9 ☐ 10 ☐ 11 ☐ 12	

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	YES	NO
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 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?	☐	☐
BRAIN/HEAD INJURY HISTORY	YES	NO
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	YES	NO
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	YES	NO
Use a brace, orthotic, or another 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	YES	NO
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	YES	NO
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 bone, muscle, or joint that bothers them?	☐	☐
Have joints that become painful, swollen, warm, or red with use?	☐	☐
Ever been diagnosed with a stress fracture?	☐	☐

Student Name:		DOB:	
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DOES OR HAS YOUR CHILD		
HEART HEALTH		
Ever complained of:	YES	NO
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:		

DOES OR HAS YOUR CHILD		
FEMALES ONLY	YES	NO
Have regular periods?	☐	☐
MALES ONLY	YES	NO
Have only one testicle?	☐	☐
Have groin pain or a bulge, or a hernia?	☐	☐
SKIN HEALTH	YES	NO
Currently have any rashes, pressure sores, or other skin problems?	☐	☐
Ever had a herpes or MRSA skin infection?	☐	☐
COVID-19 INFORMATION		
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	☐ Brugada Syndrome?
☐ Arrhythmogenic Right Ventricular Cardiomyopathy?	☐ Catecholaminergic Ventricular Tachycardia?
☐ Heart rhythm problems, long or short QT interval?	☐ 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 <u>all</u> questions, STOP. Sign and date below. GO to page 3 if you answered YES to a question.	
Parent/Guardian Signature:	Date:

