# Fort Edward UFSD
## Interval Health History for Athletics

| Student Name: | DOB: |
|---|---|
| School Name: Fort Edward UFSD | 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.**

SINCE YOUR CHILD'S LAST HEALTH EXAM – HAS YOUR CHILD?

| General Heath | NO | YES |
|---|---|---|
| Been restricted by a health care provider from sports participation for any reason? | ☐ | ☐ |
| Had surgery? | ☐ | ☐ |
| Spent the night in a hospital? | ☐ | ☐ |
| Been diagnosed with mononucleosis within the last month? | ☐ | ☐ |
| Has only one functioning kidney? | ☐ | ☐ |
| Has or had a bleeding disorder? | ☐ | ☐ |
| Having problems with hearing or have congenital deafness? | ☐ | ☐ |
| Having problems with vision or only have vision in one eye? | ☐ | ☐ |
| Been diagnosed with a new medical condition? | ☐ | ☐ |
| If yes, check all that apply:<br>☐ Asthma ☐ Diabetes<br>☐ Seizures ☐ Sickle cell trait or disease<br>☐ Other: ______________________________ | | |
| Developed Allergies? | ☐ | ☐ |
| If yes, check all that apply<br>☐ Food ☐ Insect Bite ☐ Latex<br>☐ Medicine ☐ Pollen<br>☐ Other: ______________________________ | | |
| Had anaphylaxis? | ☐ | ☐ |
| Carry an epinephrine auto-injector? | ☐ | ☐ |
| Had or has groin pain, a bulge, or a hernia? | ☐ | ☐ |
| **Devices / Accommodations** | **NO** | **YES** |
| Uses a brace, orthotic, or another device? | ☐ | ☐ |
| Has special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)? | ☐ | ☐ |
| Wears protective eyewear, such as goggles or a face shield? | ☐ | ☐ |
| Wears a hearing aid or cochlear implant? | ☐ | ☐ |

**Let the coach/school nurse know of any device used. Not required for contact lenses or eyeglasses.**

SINCE YOUR CHILD'S LAST HEALTH EXAM – HAS YOUR CHILD?

| Brain/Head Injury History | NO | YES |
|---|---|---|
| Has or had a hit to the head that caused headache, dizziness, nausea, or confusion, or been told they had a concussion? | ☐ | ☐ |
| Received treatment for a seizure disorder or epilepsy? | ☐ | ☐ |
| Has or had headaches with exercise? | ☐ | ☐ |
| Has or had migraines? | ☐ | ☐ |
| **Breathing** | **NO** | **YES** |
| Complained of getting extremely tired or short of breath during exercise? | ☐ | ☐ |
| Used or carries an inhaler or nebulizer? | ☐ | ☐ |
| Has or had wheezing or coughing frequently during or after exercise? | ☐ | ☐ |
| Been told by a health care provider they have asthma or exercise-induced asthma? | ☐ | ☐ |
| **Digestive (GI) Health** | **NO** | **YES** |
| Has or had stomach or other GI problems? | ☐ | ☐ |
| Has an eating disorder? | ☐ | ☐ |
| Has a special diet or need to avoid certain foods? | ☐ | ☐ |
| Do you have concerns about your child's weight? | ☐ | ☐ |
| **Injury History** | **NO** | **YES** |
| Been unable to move their arms or legs or had tingling, numbness, or weakness after being hit or falling? | ☐ | ☐ |
| Had an injury, pain, or joint swelling caused them to miss practice or a game? | ☐ | ☐ |
| Has or had a bone, muscle, or joint that bothers them? | ☐ | ☐ |
| Has or had joints that become painful, swollen, warm, or red with use? | ☐ | ☐ |
| Been diagnosed with a stress fracture? | ☐ | ☐ |
| **Females Only** | **NO** | **YES** |
| Change in period frequency related to female athlete triad? | ☐ | ☐ |
| **Males Only** | **NO** | **YES** |
| Has only one testicle? | ☐ | ☐ |

| Student Name: | DOB: |
|---|---|

| SINCE YOUR CHILD'S LAST HEALTH EXAM – HAS YOUR CHILD? | | |
|---|---|---|
| **Skin Heath** | **NO** | **YES** |
| Has any rashes, pressure sores, or other skin problems? | ☐ | ☐ |
| Has a herpes or MRSA skin infection? | ☐ | ☐ |
| **COVID-19 Information** | **NO** | **YES** |
| Child tested positive for COVID-19? | ☐ | ☐ |
| If **NO, STOP** and go to Family Heart Health History. If **YES**, answer the questions below: | | |
| Date of positive COVID test: | | |
| Was your child symptomatic? | ☐ | ☐ |
| Did your child see a healthcare provider for their COVID-19 symptoms? | ☐ | ☐ |
| Was your child hospitalized for COVID? | ☐ | ☐ |
| Was your child diagnosed with Multisystem Inflammatory Syndrome (MISC)? | ☐ | ☐ |

| SINCE YOUR CHILD'S LAST HEALTH EXAM – HAS YOUR CHILD? | | |
|---|---|---|
| **Heart Health** | **NO** | **YES** |
| Had a test by a health care provider for their heart (e.g., EKG, echocardiogram, stress test)? | ☐ | ☐ |
| Has or had lightheadedness or dizziness during or after exercise? | ☐ | ☐ |
| Has or had chest pain, tightness, or pressure during or after exercise? | ☐ | ☐ |
| Has or had fluttering in the chest, skipped heartbeats, heart racing? | ☐ | ☐ |
| Been told by a healthcare provider they have or had a heart or blood vessel problem? | ☐ | ☐ |
| **If yes, check all that apply:** | ☐ | ☐ |

☐ Chest Tightness or Pain ☐ Heart Infections
☐ High Blood Pressure ☐ Heart Murmur
☐ Low Blood Pressure ☐ High Cholesterol
☐ New fast or slow heart rate ☐ Kawasaki Disease
☐ Has implanted cardiac defibrillator (ICD)
☐ Had a pacemaker implanted
☐ Other:
______________________________________________________

**SINCE YOUR CHILD'S LAST HEALTH EXAM – CHECK ANY <u>NEW</u> FAMILY HEART HEALTH HISTORY**

A relative had or is currently experiencing 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?
- ☐ Structural heart abnormality, repaired or unrepaired?
- ☐ Known heart abnormalities or sudden death before age 50?
- ☐ Unexplained fainting, seizures, drowning, near drowning, or car accident before age 50?
- ☐ Brugada Syndrome?
- ☐ Catecholaminergic Ventricular Tachycardia?
- ☐ Marfan Syndrome (aortic rupture)?
- ☐ Heart attack at age 50 or younger?
- ☐ Pacemaker or implanted cardiac defibrillator (ICD)?

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.

☐ Information on this form is <u>NEW</u> information since my child's last health examination.

| Parent/Guardian Signature: | Date: |
|---|---|

| Student Name: | DOB: |
|---|---|
| If you answered **YES** to any questions, give details. Sign and date below. | |
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| Parent/Guardian Signature: | Date: |