

## NYSED Interval Health History for St. Francis Athletics

Student Name:		DOB:	
		Age:	
Grade (check): <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		Date of last Health Exam	
		Date form completed:	
<b>MUST be completed and signed by Parent/Guardian – Complete no SOONER than within 30 Days of tryouts</b>			

DOES OR HAS YOUR CHILD		
GENERAL HEALTH	No	YES
Ever been restricted by a health care provider from sports participation for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>
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"/>
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 headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had migraines?	<input type="checkbox"/>	<input type="checkbox"/>

BREATHING	No	YES
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DOES OR HAS YOUR CHILD		
Ever complained of getting extremely tired or short of breath during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Use or carry an inhaler or nebulizer?	<input type="checkbox"/>	<input type="checkbox"/>
Wheeze or cough frequently during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Ever been told by a health care provider they have asthma or exercise-induced asthma?	<input type="checkbox"/>	<input type="checkbox"/>
DEVICES / ACCOMMODATIONS	No	YES
Use a brace, orthotic, or another device?	<input type="checkbox"/>	<input type="checkbox"/>
Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
Wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
Wear a hearing aid or cochlear implant?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Let the coach/school nurse know of any device used. Not required for contact lenses or eyeglasses.</b>		
DIGESTIVE (GI) HEALTH	No	YES
Have stomach or other GI problems?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Have a special diet or need to avoid certain foods?	<input type="checkbox"/>	<input type="checkbox"/>
Are there any concerns about your child's weight?	<input type="checkbox"/>	<input type="checkbox"/>
INJURY HISTORY	No	YES
Ever been unable to move their arms or legs or had tingling, numbness, or weakness after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had an injury, pain, or swelling of a joint that caused them to miss practice or a game?	<input type="checkbox"/>	<input type="checkbox"/>
Have a bone, muscle, or joint that bothers them?	<input type="checkbox"/>	<input type="checkbox"/>
Have joints that become painful, swollen, warm, or red with use?	<input type="checkbox"/>	<input type="checkbox"/>
Ever been diagnosed with a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>
Lightheadedness, dizziness, during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>

Student Name:		DOB:	
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DOES OR HAS YOUR CHILD		
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:		

MALES ONLY	NO	YES
Have only one testicle?	<input type="checkbox"/>	<input type="checkbox"/>

DOES OR HAS YOUR CHILD		
Have groin pain or a bulge, or a hernia?	<input type="checkbox"/>	<input type="checkbox"/>
<b>SKIN HEALTH</b>	<b>NO</b>	<b>YES</b>
Currently have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had a herpes or MRSA skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
<b>COVID-19 INFORMATION</b>		
Has your child ever tested positive for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
If <b>NO, STOP</b> . Go to Family Heart Health History. If <b>YES</b> , answer questions below:		
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:	
<input type="checkbox"/> Enlarged Heart/ Hypertrophic Cardiomyopathy/ Dilated Cardiomyopathy	<input type="checkbox"/> Brugada Syndrome?
<input type="checkbox"/> Arrhythmogenic Right Ventricular Cardiomyopathy?	<input type="checkbox"/> Catecholaminergic Ventricular Tachycardia?
<input type="checkbox"/> Heart rhythm problems, long or short QT interval?	<input type="checkbox"/> Marfan Syndrome (aortic rupture)?
	<input type="checkbox"/> Heart attack at age 50 or younger?
	<input type="checkbox"/> Pacemaker or implanted cardiac defibrillator (ICD)?
A family history of:	
<input type="checkbox"/> Known heart abnormalities or sudden death before age 50?	<input type="checkbox"/> Structural heart abnormality, repaired or unrepaired?
<input type="checkbox"/> Unexplained fainting, seizures, drowning, near drowning, or car accident before age 50?	

If you answered <b>NO</b> to <b>all</b> questions, <b>STOP</b> . Sign and date below, then sign and date page 3. <b>GO</b> to page 4 if you answered <b>YES</b> to a question.	
Parent/Guardian Signature:	Date:

Student Name:		DOB:	
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**Please be aware of this information regarding Concussion :**

Concussion or mild traumatic brain injury ( TBI) is a common problem in sports that has a potential for serious complications if not managed correctly. Even what appears to be a “minor ding” or “bell ringer”, without the loss of consciousness, has the risk of serious results in a teenager who has returned to action too soon. St. Francis High School follows the guidelines and procedures outlined in the consensus statement from the International Conference on Concussion in Sport and procedures for ImPACT Concussion testing. These guidelines are based on the awareness of the increased vulnerability of the brain to concussions occurring close together and the cumulative effects of multiple concussions on long-term cognitive function. The cornerstone of concussion management is physical & cognitive rest until symptoms resolve followed by a stepwise return to play protocol. The school nurse will notify the student’s teachers of the recent head injury as post concussion symptoms may interfere with the student’s ability to fully concentrate in the classroom.

All contact sport athletes will complete a baseline ImPACT test every 2 years. For more information on concussions and the ImPACT test see:

[www.cdc.gov/concussion/sports/](http://www.cdc.gov/concussion/sports/)

[www.impacttest.com](http://www.impacttest.com)

**Parental Permission and Authorization for Emergency Treatment**

I, the undersigned, clearly understand the concussion information and that the questions are asked in order to decide if my son can safely participate on the Athletic team named on the front part of this form. I understand that in order to best meet the needs of the athlete, relevant health information may need to be shared with the coach or athletic trainer. The answers are correct as of this date and he has my permission to participate. In case of emergency, if I cannot be reached, I authorize my son to receive emergency treatment including treatment by a doctor other than our family physician.

**Date:** \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_

**Complete NO SOONER than within 30 days of tryouts**

If you answered <b>YES</b> to any questions give details. Sign and date below.
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