NEW HARTFORD CENTRAL SCHOOL
Pre-Participation/Interval Sports Health History

Name_____________________________________________   Age_______  Grade________  M/F_______
Sport_____________________________________________   Date_______________________

The Health History must be completed by a parent BEFORE sports participation and try outs for each sports season.

1. Did your child ever have an illness that:
   a. Required him/her to stay in the hospital? ___  ___
   b. Lasted longer than a week? ___  ___
   c. Caused him/her to miss 3 days of practice or a competition? ___  ___
   d. Is related to allergies (ie: hay fever, hives, asthma, insect stings) ___  ___
   e. Required an operation? ___  ___
   f. Is chronic? (ie: asthma, diabetes, etc) ___  ___

2. Has your child ever had an injury that:
   a. Required him/her to go to an emergency room or to see a doctor? ___  ___
   b. Required him/her to stay in the hospital? ___   ___
   c. Required x-rays? ___  ___
   d. Caused him/her to miss 3 days of practice or a competition? ___  ___
   e. Required an operation? ___  ___

3. Does your child take any medication or pills? ___  ___

4. Have any family members under age 50 had a heart attack, heart problem or died unexpectedly? ___   ___

5. Has your child ever had a heart murmur, high blood pressure or heart abnormality? ___  ___

6. Has your child ever complained of chest pain, tightness or pressure during or after practice? ___  ___

7. Has your child ever complained of fluttering in their chest, skipped beats, or their heart racing? ___  ___

8. Has a health care provider ever ordered a test for his/her heart? ___  ___

9. Has your child been told she/he has a heart condition or problem? ___  ___

10. Has your child ever been dizzy or passed out during exercise? ___  ___

11. Is your child able to run ½ mile (2x around the track) without stopping? ___  ___

12. Has your child ever had heat exhaustion, heat stroke, or other heat related problems? ___  ___

13. Has your child ever been unconscious or had a concussion? ___  ___

14. Does your child have:
   a. frequent headaches? ___  ___
   b. wear glasses or contacts? ___  ___
   c. wear dental bridges, plates, braces, special pads, protective equipment, or wear a medical device? ___  ___

15. Does your child have any allergies to any Medicine? Food? Environment? ___  ___

16. Is your child missing one of any paired organ? (eye, kidney, etc.) ___  ___

17. Does your child have problems with anxiety or depression? ___  ___

18. Is your child currently having physical therapy, chiropractic treatment, or other therapy? ___  ___

Are there any changes in your child’s health since their last physical exam? ____________________________________________________________

Please explain any “yes” answers on the back of this form (or a “no” answer to # 11).

Parental Permission: I, the undersigned, clearly understand these questions are asked in order to decide in my child can safely participate on an athletic team. The answers are correct as of this date and he/she has my permission to participate. I also give permission to the health office to disclose pertinent health information to the athletic department.

Signature of Parent: _____________________________________________  Date: ____________________
Please explain fully any question you answered yes to in the space below. (Please print clearly and provide dates if known):