**UNION SPRINGS CENTRAL SCHOOL DISTRICT**

**INTERVAL HEALTH HISTORY FOR SPORTS PARTICIPATION**

TO BE COMPLETED BY PARENT/GUARDIAN AND RETURNED TO THE SCHOOL HEALTH OFFICE

**PART A:**

Student Age:

Grade (check): [ ]  7 [ ]  8 [ ]  9 [ ]  10 [ ] 11 [ ]  12 Date of Birth

Sport: Level (check): [ ]  Varsity [ ]  JV [ ]  Modified

Date of last health appraisal: Limitations: [ ]  Yes [ ]  No

**PART B:**

**Note:** “Yes” to any of these questions does not mean automatic disqualification from the athletic activity indicated in PART A above. However, it may require a review and approval by the school physician before the student can report to practice or tryouts.

**HISTORY SINCE LAST HEALTH APPRAISAL**

Allergies (Bee Sting/Medications/Food/Latex, etc.) [ ]  Yes [ ]  No

 Does the student carry and Epi-Pen® for a life threatening allergy: [ ]  Yes [ ]  No

Asthma [ ]  Yes [ ]  No

 Does the student carry an inhaler? [ ]  Yes [ ]  No

Concussion/Head Injury/Seizures [ ]  Yes [ ]  No

Recent injury that requires medical attention or protective equipment? [ ]  Yes [ ]  No

Recent illness lasting longer than one week (ie. Mono)? [ ]  Yes [ ]  No

Currently taking medications [ ]  Yes [ ]  No

Diabetes/Hypoglycemia [ ]  Yes [ ]  No

Heart/Blood Pressure Problems [ ]  Yes [ ]  No

Heat Exhaustion or Stroke [ ]  Yes [ ]  No

Hearing Impairment [ ]  Yes [ ]  No

Bleeding Tendency/Anemia [ ]  Yes [ ]  No

Recent Surgery or Hospitalization [ ]  Yes [ ]  No

Kidney/Liver Disease [ ]  Yes [ ]  No

Contact Lenses [ ]  Yes [ ]  No

Is there any medical condition that might be aggravated by playing sports? [ ]  Yes [ ]  No

**PART C: TO BE COMPLETED BY PARENT OR GUARDIAN**

Describe the condition or situation that caused any question in PART B to be answered “Yes”.

**PART D: PARENT PERMISSION**

I, the undersigned, clearly understand these questions are asked in order to decide if my child can safely participate on the athletic team named in PART A of this form. The answers are correct as of this date and he/she has my permission to participate.

SIGNATURE: DATE: / /

**PART E: CONCUSSION AWARENESS**

I have read the attached Concussion Fact Sheet. I understand that in the event of any head injury, my child will be immediately removed from play and that the school must receive documentation of medical treatment prior to returning to any sports activities.

SIGNATURE:

You can view the school’s full concussion policy at [www.uscsd.org/](http://www.uscsd.org/) or obtain a copy through the High School main office or health office.

**PLEASE RETURN TO THE SCHOOL HEALTH OFFICE**

**PART F: TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE**

 Sports Participation: [ ]  Approved [ ]  Referred to School Physician

 Signed: Date: / /

 School Health Office

 If referred to the School Physician: [ ]  Requalified [ ]  Disqualified

 Signed: Date: / /

 School Physician