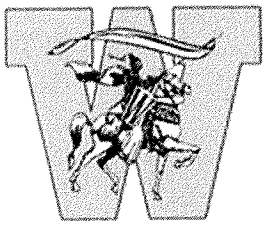
Windsor Central School District
Interval Health History Form



Student Name:_____

DOB:_____**Age:**_____**School Name:**_____

Grade:_____**Sport:**_____**Modified**_____ **JV**_____ **Varsity**_____

Primary Care Physician:_____**Date of Last Health Exam:**_____

-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?

- Been restricted by a health care provider from sports participation for any reason? ☐ Yes ☐ No
- Had surgery? ☐ Yes ☐ No
- Spent the night in the hospital? ☐ Yes ☐ No
- Been diagnosed with mono within the last month? ☐ Yes ☐ No
- Has only one functioning kidney? ☐ Yes ☐ No
- Has/had a bleeding disorder? ☐ Yes ☐ No
- Having problems with hearing or have congenital deafness? ☐ Yes ☐ No
- Having problems with vision or only having vision in one eye? ☐ Yes ☐ No
- Been diagnosed with a new medical condition? ☐ Yes ☐ No -If yes, select any/all that apply: ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Sickle cell Trait/disease ☐ Other: _____
- MALES ONLY- Has only one testicle? ☐ Yes ☐ No
- Developed allergies? ☐ Yes ☐ No -If yes, check any/all that apply: ☐ Food ☐ Insect Bite ☐ Latex ☐ Medicine ☐ Pollen ☐Other: _____
- Had anaphylaxis? ☐ Yes ☐ No If yes, do you carry an epi-pen? ☐ Yes ☐ No
- FEMALES ONLY- Change in menses frequency related to female athlete triad? ☐ Yes ☐ No

DEVICES/ACCOMMODATIONS

- Uses a brace, orthotic, or another device? ☐ Yes ☐ No
- Has special devices/prostheses (insulin pump, continuous glucose monitor, ostomy bag, etc?) ☐ Yes ☐ No
- Wears protective eyewear, such as a face shield or goggles? ☐ Yes ☐ No
- Wears a hearing aid or cochlear implant? ☐ Yes ☐ No

***Let the coach/school nurse know of any other devices used that are not listed.**

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

BRAIN/HEAD INJURY HISTORY

- Has/had a hit to the head that caused a headache, dizziness, confusion, nausea, or has been told they had a concussion? ☐ Yes ☐ No
- Received treatment for seizure disorder or epilepsy? ☐ Yes ☐ No
- Has/had migraines? ☐ Yes ☐ No
- Has/had headaches while exercising? ☐ Yes ☐ No

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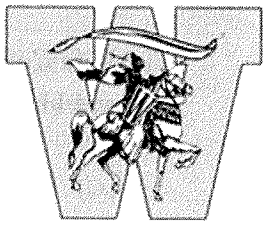

SINCE YOUR CHILD'S LAST HEALTH EXAM- HAS YOUR CHILD?

BREATHING HISTORY

- Complained of getting extremely tired or short of breath during physical activity/exercise? ☐ Yes ☐ No
- Prescribed/used/carries an inhaler or nebulizer? ☐ Yes ☐ No
- Has/had wheezing and/or coughing during or after physical activity/exercise? ☐ Yes ☐ No
- Been told by a healthcare provider they have asthma/exercise-induced asthma? ☐ Yes ☐ No

DIGESTIVE (GI) HEALTH HISTORY

- Has/had stomach or other GI problems? ☐ Yes ☐ No
- Has an eating disorder? ☐ Yes ☐ No
- Has a special diet or needs to avoid certain foods? ☐ Yes ☐ No
- Do you have concerns about your child's weight? ☐ Yes ☐ No

INJURY HISTORY

- Recent/history of inability to move arms or legs or had/have tingling, numbness, or weakness after being hit or falling? ☐ Yes ☐ No
- Had injury, pain, or joint swelling causing them to miss practice or a game? ☐ Yes ☐ No
- Has/had a bone, muscle or joint that bothers them? ☐ Yes ☐ No
- Has/had joints that become painful, swollen, warm, or red with use? ☐ Yes ☐ No
- Has/had diagnosis of stress fracture? ☐ Yes ☐ No
- Has/had groin pain, a bulge, or a hernia? ☐ Yes ☐ No
- Had/have a heart or blood vessel problem? ☐ Yes ☐ No

SKIN HEALTH

- Has/had rashes, pressure sores, or other skin problems? ☐ Yes ☐ No
- Has/had a Herpes or MRSA skin infection ☐ Yes ☐ No

COVID-19 INFORMATION

- Has your child ever tested positive for COVID-19? ☐ Yes ☐ No If so, when: ___ _____
- Was your child symptomatic? ☐ Yes ☐ No
- Did your child see a medical provider for their COVID-19 symptoms? ☐ Yes ☐ No
- Was your child hospitalized for COVID19? ☐ Yes ☐ No
- Was your child diagnosed with MISC? (Multisystem Inflammatory Syndrome) ☐ Yes ☐ No

HEART HEALTH

- Had testing by medical provider for their heart? (ex: EKG, ECHO, stress test) ☐ Yes ☐ No
- Has/had lightheadedness/dizziness after or during physical activity/exercise? ☐ Yes ☐ No
- Has/had chest pain, tightness, or pressure in chest after or during physical activity/ exercise? ☐ Yes ☐ No
- Has/had fluttering in the chest, skipped or racing heartbeats? ☐ Yes ☐ No

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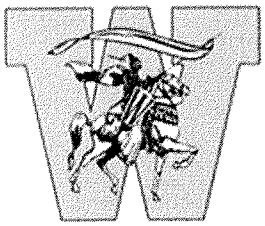

SINCE YOUR CHILD'S LAST HEALTH EXAM- CHECK ANY NEW FAMILY HEART HEALTH HISTORY

☐ Enlarged Heart/Hypertrophic Cardiomyopathy/Dilated Cardiomyopathy

☐ Brugada Syndrome ☐ Catecholaminergic Ventricular Tachycardia ☐ Heart attack age 50 or younger? If so, did this family member have other diagnoses/comorbidities ☐Yes ☐ No

☐ Heart rhythm problems: long or short QT intervals? ☐ Marfan Syndrome (aortic rupture)

☐ Arrhythmogenic Right Ventricular Cardiomyopathy ☐ Pacemaker/implanted cardiac defibrillator (ICD)? ☐ Structural heart abnormality? If so, has this been repaired? ☐ Yes ☐ No

☐ Known heart abnormalities or sudden death before age 50? If so, did this family member have other diagnoses/comorbidities ☐Yes ☐ No

☐Unexplained fainting, seizures, drowning, near drowning, or car accident before age 50?

If you answered YES to any question, please give further details below. Sign and date at the bottom.

_____

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Parent Signature:_____**Date:**_____

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