FONDA FULTONVILLE CENTRAL SCHOOL
PRE-PARTICIPATION/INTERVAL ATHLETIC HEALTH HISTORY

Student:_____ Age:_____

Grade (check): ❑ 7 ❑ 8 ❑ 9 ❑ 10 ❑ 11 ❑ 12 Date of Birth: ____/____/____

Sport:_____ Level (check): ❑ Varsity ❑ JV ❑ Modified

Date of last health exam: _____/_____/_____ Limitations: ❑ Yes ❑No

Health History to be completed by parent/guardian

Answer questions below to indicate if your child has or has ever had the following and provide details to any yes answer on back:

Question	YES	NO
Has a doctor or nurse practitioner (a health care provider) ever restricted his/her participation in sports for any reason?		
Does s/he have an ongoing medical condition? Please check below: ❑ Asthma ❑ Diabetes ❑Seizures ❑ Other ❑ Sickle Cell trait or disease		
Has s/he ever had surgery?		
Has s/he ever spent the night in a hospital?		
Does s/he have a life threatening allergy? Please check below: ❑ Medication ❑ Food ❑ Insect bites ❑ Pollen ❑Latex ❑ Other		
Does s/he carry an Epi-pen (epinephrine)?		
Has s/he ever passed out during or after exercise?		
Has s/he ever complained of light headedness or dizziness during or after exercise?		
Has s/he ever complained of chest pain, tightness or pressure during or after exercise?		
Has s/he ever complained of fluttering in their chest, skipped beats, or their heart racing, or does s/he have a pacemaker?		
Has a health care provider ever ordered a test for his/her heart? (ex. EKG, echocardiogram, stress test)		
Has s/he been told s/he has a heart condition or problem?		
Has s/he ever had high or low blood pressure?		
Has s/he ever complained of getting more tired or short of breath than his/her friends during exercise?		
Does s/he wheeze or cough frequently during or after exercise?		
Has a health care provider ever said s/he has asthma?		
Does s/he use or carry an inhaler or nebulizer?		
Has s/he ever become ill while exercising in hot weather?		
Is s/he on a special diet or have to avoid certain foods?		
Does s/he worry about their weight?		

Question	YES	NO
Does s/he have stomach problems?		
Has s/he ever had a hit to the head that caused a headache, dizziness, nausea, or confusion, or been told s/he had a concussion?		
Does s/he ever have headaches with exercise?		
Has s/he ever had a seizure?		
Is s/he currently being treated for a seizure disorder or epilepsy?		
Has s/he ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling?		
Has s/he ever an injury, pain, or swelling of joint that caused him/her to miss practice or a game?		
Does s/he use a brace, orthotic or other device?		
Does s/he have any problems with his/her hearing or wear hearing aides?		
Does s/he have any problems with his/her vision or have vision in one eye only?		
Does s/he wear glasses or contacts?		
Has s/he ever had a hernia?		
Does s/he have only 1 functioning kidney?		
Does s/he have a bleeding disorder?		
Females Only	**YES**	**NO**
Has she had her period? At what age did it begin? _____		
How often does she get her period?		
Date of last menstrual period_____		
Males Only	**YES**	**NO**
Does he have only one testicle?		
Family History	**YES**	**NO**
Has any relative been diagnosed with a heart condition or developed hypertrophic cardiomyopathy, Marfan Syndrome, right ventricular cardiomyopathy, long QT or short QT syndrome, Brugada Syndrome, or catecholaminergic polymorphic ventriculartachycardia?		
Has any relative died suddenly before the age of 50 from unknown or heart related cause?		

Please explain fully any question you answered yes to in the space below (Please print clearly, and provide dates if known):

PARENTAL 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 on this form. **I certify that to the best of my knowledge my answers are complete and true as of this date and he/she has my permission to participate.**

SIGNED: _____ DATE: ____/____/____

TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE

Sports Participation: ❑ Qualified ❑ Re-Interviewed ❑ Referred to School Physician

Signed: _____ Date: ____/____/____
School Health Office

If referred to the School Physician: ❑ Requalified ❑ Disqualified

Signed: _____ Date: ____/____/____
School Physician