

Dutchess Day School
Interval Health History for Sports Participation
2010-2011

This form must be turned in prior to the start of tryout sessions or practice at the beginning of each season, a health history review for each athlete must be conducted unless the student received a full medical examination within 30 days of the start of the season. In order for 12-month physical to be valid-Interval Health History must be completed (as Per NYS Education Department).

PART A: TO BE COMPLETED BY SCHOOL HEALTH OFFICE

Student: _____ **Date of Last Health Appraisal:** _____
Date of Birth: _____ **Age:** _____ **Grade:** _____

PART B: TO BE COMPLETED BY PARENT/GUARDIAN

Sport: Please check appropriate box below.

Cross Country Soccer Field Hockey Squash Basketball Volleyball Lacrosse Tennis Golf
My child will not be participating in a sport this season (**do not fill out rest of form**)

HEALTH HISTORY SINCE LAST HEALTH APPRAISAL:

YES NO

- Any injuries requiring medical attention?
- Any illness lasting more than 5 days?
- Taking medicine or under physician's care at this time?
- Any feeling of faintness, dizziness or fatigue after exercise or exertion?
- Change in wearing glasses or contact lenses?
- Any surgical operations or fractures?
- Any treatment in a hospital or emergency room?
- Developed any allergies/asthma (including bee and food)?
- Any Chronic disease?
- Joint Sprain/Ligament Tear/Muscle Pull/Dislocation

Please describe the condition or situation that caused any of the above questions to be answered 'YES'" (include medications).
Note: "Yes" answers to any of these questions does not mean automatic disqualification from the athletic activity indicated.
They will require review and evaluation.

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

Parent Signature: _____ Date: _____

PART C: TO BE COMPLETED BY SCHOOL HEALTH OFFICE AND ATHLETIC DIRECTOR

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|---------------------------------|----------|--------------------------------------|
| Sports Participation: | Approved | Referred to Physician |
| If referred to Physician: | Approved | Disqualified |
| Initials of School Nurse: _____ | | Initials of Athletic Director: _____ |
| Date: _____ | | Date: _____ |

