NYSED Interval Health History for Athletics

			<u> </u>			
Student Name:			DOB			
School Name:			Age			
Grade (check): \Box 7 \Box 8 \Box 9 \Box						
Sport			Date of last Health Exam:			
Sport Level: Modified Fresh		□ Var	gity.			
•			Date form completed.			
MUST be completed and signed by Par	rent/Gu	ıardian -	- Give details to any YES answers on the last pa	ge.		
DOES OR HAS YOUR CHILD			DOES OR HAS YOUR CHILD			
GENERAL HEALTH	NO	YES	BREATHING	NO	YES	
Ever been restricted by a health care provider from sports participation for any reason?			Ever complained of getting extremely tired or short of breath during exercise?			
Ever had surgery?			Use or carry an inhaler or nebulizer?			
Ever spent the night in a hospital?			Wheeze or cough frequently during or after exercise?			
Been diagnosed with mononucleosis			Ever been told by a health care provider they			
within the last month?			have asthma or exercise-induced asthma?	NO	VEC	
Have only one functioning kidney?			DEVICES / ACCOMMODATIONS	NO	YES	
Have a bleeding disorder?			Use a brace, orthotic, or anther device?	H		
Have any problems with hearing or have congenital deafness?			Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)?			
Have any problems with vision or only have vision in one eye?			Wear protective eyewear, such as goggles or a face shield?			
Have an ongoing medical conditions?			Wear a hearing aid or cochlear implant?			
If yes, check all that apply:			Let the coach/school nurse know of any dev		sed.	
☐ Asthma☐ Diabetes☐ Seizures☐ Sickle cell trait or diseas	2		Not required for contact lenses or eyegl	asses		
☐ Seizures ☐ Sickle cell trait of diseas ☐ Other:	e		DIGESTIVE (GI) HEALTH	NO	YES	
Have Allergies?			Have stomach or other GI problems?			
☐ Food ☐ Insect Bite ☐ Latex	□ Medi	cine	Ever had an eating disorder?			
□ Pollen □ Other:			Have a special diet or need to avoid certain foods?			
Ever had anaphylaxis?			Are there any concerns about your child's			
Carry an epinephrine auto-injector?			weight?			
BRAIN/HEAD INJURY HISTORY	NO	YES	INJURY HISTORY	NO	YES	
Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told they had a concussion?			Ever been unable to move their arms or legs or had tingling, numbness, or weakness after being hit or falling?			
Receive treatment for a seizure disorder or epilepsy?			Ever had an injury, pain or swelling of a joint that caused them to miss practice or a game?			
Ever had headaches with exercise?			Have a bone, muscle, or joint that bothers them?			
Ever had migraines?			Have joints that become painful, swollen, warm or red with use?			
			Ever been diagnosed with stress fracture?		<u></u>	

DOES OR HAS YOUR CHILD			DOES OR HAS YOUR CHILD				
HEART HEALTH	NO	YES	FEMALES ONLY	NO	YES		
Every complained of:		<u> </u>	Have regular periods?				
Ever had a test by a health care provider			MALES ONLY	NO	YES		
for their heart (e.g., EKG, echocardiogram, stress test)?			Have only on testicle?				
Lightheadedness, dizziness, during or			Have groin pain or a bulge, or a hernia?				
after exercise?			SKIN HEALTH	NO	YES		
Chest pain, tightness, or pressure during or after exercise?			Currently have any rashes, pressure sores, or other skin problems?				
Fluttering in the chest, skipped heartbeats, heart racing?			Ever had a herpes or MRSA skin infection?				
Ever been told by a health care provider			COVID-19 INFORMATION	NO	YES		
they have or had a heart or blood vessel problem? If yes, check all the apply:			Has your child ever tested positive for COVID-19? If NO. STOP. Co to Family Heart Health				
☐ Chest Tightness or Pain ☐ Heart Infection			If NO , STOP . Go to Family Heart Health History. If YES , answer questions below:				
☐ High Blood Pressure ☐ Heart Murmur			Date of positive COVID test:				
☐ High Cholesterol ☐ Low Blood Pressure			Was your child symptomatic?				
☐ New fast or slow heart rate ☐ Kawasaki Disease			Did your child see a health care provider for				
☐ Has implanted cardiac defibrillator (ICD)			their COVID-19 symptoms?				
☐ Has a pacemaker			Was your child hospitalized for COVID?				
☐ Other:			Was your child diagnosed with Multisystem				
			Inflammatory Syndrome (MISC)?				
FAMILY HEART HEALTH HISTOR	Y						
 A relative has/had any of the following: Check all that apply: □ Enlarged Heart/Hypertrophic Cardiomy Cardiomyopathy □ Arrhythmogenic Right Ventricular Cardiomyopathy □ Heart rhythm problems, long or short Q 	liomyc	pathy?	 □ Brugada Syndrome? □ Catecholaminergic Ventricular Tachycardia? □ Marfan Syndrome (aortic rupture)? □ Heart attack at age 50 or younger? □ Pacemaker or implanted cardiac defibrillator (ICD)? 				
A family history of: ☐ Known heart abnormalities or sudden d ☐ Structural heart abnormality, repaired o ☐ Unexplained fainting, seizures, drowning	r unrep	paired?					
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			stions, STOP , Sign and date below. ons give details below then sign and date.				
Parent/Guardian Signature:			Date				