Hauppauge School District Interval Health History for Athletics

Student Name:_____ DOB_____ HS ☐ MS ☐

Sport:_____ Grade (check) ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

GENERAL HEALTH:

Ever been restricted by a health care provider from sports participation for any reason? Yes___ No___

Ever had Surgery? Yes___ No ___

Any Other Injury requiring medical attention or hospital visit? Yes__ No__ Describe:_____

Taking any medications at this time? Yes__ No __ Describe:_____

Been diagnosed with mononucleosis within the last month Yes___ No ___

Have any problems with vision or only have vision in one eye Yes___ No ___

Have any ongoing medical conditions? If yes check all that apply: ☐ One functioning kidney ☐ Bleeding Disorder

☐ Asthma ☐ Seizures ☐ Diabetes ☐ Sickle cell trait or disease ☐ Only one testicle ☐ Other:_____

Have Allergies? If yes check all that apply: ☐ Pollen ☐ Insect Bite ☐ Latex ☐ Other:_____

☐ Food:_____ ☐ Medicine:_____

Carry an epinephrine auto-injector? Yes___ No___ (Must have medication order on file)

BRAIN/ HEAD INJURY History:

Suffered any head injuries/concussions with or without loss of consciousness during his/her lifetime?

Yes___ No___ When?_____ Did loss of consciousness occur? Yes___ No___

BREATHING:

Ever complained of getting extremely tired or short of breath during exercise? Yes___ No___

Do you have: ☐ Asthma ☐ Exercise-induced asthma

☐ Use or carry an inhaler or nebulizer (Must have medication order on file)

DEVICES/ACCOMMODATIONS:

Use a brace, orthotic, or another medical device? Yes ___ No ___ Describe:_____

Wear protective eyewear, such as goggles or face shield? Yes___ No___

Wear a hearing aid or cochlear implant ? Yes___ No ___

INJURY HISTORY:

Any broken bones, fractures, surgery? Yes ___ No ___ When:_____

Have joints that become painful, swollen, warm, or red with use? Yes___ No ___

EVER BEEN TOLD BY A HEALTH CARE PROVIDER:

Have or had a heart or blood vessel problem? Yes___ No___ (If yes check all that applies)

☐ Chest Tightness or Pain ☐ High Blood Pressure ☐ High Cholesterol ☐ New fast or slow heart rate

☐ Has implanted cardiac device ☐ Heart Infection ☐ Heart Murmur ☐ Low Blood Pressure

☐ Kawasaki Disease ☐ Other:_____

HEART HEALTH:

History of heart murmur ☐ Cardiac Arrhythmia ☐ Palpitations ☐

Light headedness, dizziness, during or after exercise? Yes ___ No ___

Chest pain, tightness, or pressure during or after exercise? Yes ___ No ___

Fluttering in the chest, skipped heartbeats, heart racing? Yes___ No ___

FAMILY HEART HEALTH HISTORY: A relative has/had any of the following: Check all that apply:

☐ Structural heart abnormality, repaired or unrepaired

☐ Enlarged Heart/Hypertrophic Cardiomyopathy/Dilated Cardiomyopathy ☐ Brugada Syndrome

☐ Arrhythmogenic Right Ventricular Cardiomyopathy ☐ Heart rhythm problems: long or short QT interval

☐ Catecholaminergic Ventricular Tachycardia ☐ Marfan Syndrome (aortic rupture) ☐ Heart attack at age 50 or younger

☐ Pacemaker or implanted cardiac defibrillator (ICD) ☐ Known Heart abnormalities or sudden death before age 50

For more information on Sudden Cardiac Arrest in youth see: https://www.health.ny.gov/diseases/chronic/sca/

We understand clearly that the questions are asked in order to decide if this student is in proper condition to participate in the athletic activity named at the top of this form. The answers will be kept confidentially in his/her health record in the school health office.

_____ Date:_____ _____ Date:_____

Parent Signature Student Signature

HAUPPAUGE HIGH SCHOOL/MIDDLE SCHOOL
ATHLETIC PERMISSION SLIP

Dear Athlete and Parent:

You and your child must read and complete this form and return it to the Nurse's Office **PRIOR TO** participation in any athletic activity.

NAME_____ **GRADE**_____ **DATE OF BIRTH**_____

I am aware that participating in any sports can be a dangerous activity involving **MANY RISKS OF INJURY.** I understand that the dangers and risks of participating in sports may include death, neck and spinal injuries, complete or partial paralysis, brain damage, injury to the muscular-skeletal system, as well as injury to other parts of my body. I understand that the danger of playing sports may result not only in injury, but the impairment of my future abilities to live a full and productive life.

Because of the dangers of participating in sports, I recognize the importance of following coaches instructions regarding conditioning, playing techniques, training and other team rules, etc., and agree to obey such instructions.

Signature of Student_____ **Date**_____

PARENT/GUARDIAN – READ CAREFULLY AND SIGN BELOW

I give permission for my child to participate in _____.

I have read and agree with the statement above concerning the risks involved. I also give permission for my child to receive a sports physical from the school physician.

Hauppauge Public Schools ***Concussion Protocol*** and important information regarding concussion symptoms and safety can be found under the Athletics' section of the schools website: http://hauppauge.k12.ny.us and at http://impacttest.com

It is the sole responsibility of the parent and /or guardian to furnish the Health Office with information regarding any change in health status prior to the start of a new sport season.

** If you do not want your child to receive a physical from the school physician, please check here ( ) If checked, you must obtain a physical for your child from your private physician dated **WITHIN ONE YEAR OF THE FIRST DAY OF THE CURRENT SPORTS SEASON**, and submit same to the School Nurse with this completed permission slip.

Parent Signature_____ **Phone#**_____ **Date** ___/___/___

Doctor's Name_____ **Phone #**_____