

**CORINTH CENTRAL SCHOOL DISTRICT
INTERVAL HEALTH HISTORY FOR SPORTS PARTICIPATION**

STUDENT NAME: _____ GRADE: _____

This Interval Health History Form or a Physical Exam must be dated no more than 30 days before the start of tryout sessions or practice at the beginning of each sports season.

PART A – TO BE COMPLETED BY STUDENT

STUDENT: _____ AGE: _____

SPORT: _____ DOB: _____

LEVEL (CHECK): VARSITY JV MODIFIED LIMITATIONS: YES NO

PART B – TO BE COMPLETED BY THE PARENT OR GUARDIAN

NOTE: "YES" to any of these questions does not mean automatic disqualification from the athletic activity indicated in PART A above. However, it will require a review and approval by the school nurse before the student can report to practice or tryouts.

The answers to the questions on this form will be held in the school health office and will be kept confidential.

HISTORY SINCE LAST HEALTH APPRAISAL: **EXAM DATE:** _____

If the answer to any of the following questions is "YES", in PART C on the reverse side of this form, please describe the condition or situation that prompted your answer.

(CHECK)

- | | | |
|---|------------------------------|-----------------------------|
| 1. Any injuries requiring medical attention? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2. Any illness lasting more than five (5) days? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 3. Taking medicine or under physician's care at this time? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 4. Any feeling of faintness, dizziness or fatigue after exercise or exertion? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 5. Change in wearing glasses or contact lens? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 6. Any surgical operations or fractures? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 7. Any treatment in a hospital or emergency room? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

ONGOING MEDICAL CONDITIONS:

If the answer to any of the following questions is "YES", in PART C on the reverse side of this form, please describe the condition or situation that prompted your answer. (CHECK)

- | | | |
|---|------------------------------|-----------------------------|
| 1. Any chronic disease or medical conditions? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2. Diagnosis of asthma? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 3. Use or carry Inhaler? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 4. Allergies: _____ | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

PART C – TO BE COMPLETED BY PARENT OR GUARDIAN:

Describe the condition or situation that caused any questions in PART B to be answered "YES".

PART D – 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 in PART A of this form. The answers are correct as of this date and he/she has my permission to participate. I give the school nurse permission to share with the sports coach any medical concerns my child may have.

SIGNED: _____ DATE: _____

PLEASE RETURN TO THE HEALTH OFFICE

PART E & F – TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE:

Date of last health appraisal: _____

Sports Participation (check):

Approved

Referred to School Physician

SIGNED: _____ DATE: _____
School Health Office

If referred to the School Physician (check):

Re-qualified

Disqualified

SIGNED: _____ DATE: _____
School Physician

PART F – INFORMATION TO BE SHARED WITH SPORTS COACHES:

DONE DATE _____ Signature _____