**UNION SPRINGS CENTRAL SCHOOL DISTRICT**

**INTERVAL HEALTH HISTORY FOR SPORTS PARTICIPATION**

TO BE COMPLETED BY PARENT/GUARDIAN AND RETURNED TO THE SCHOOL HEALTH OFFICE

**PART A:**

Student Age:

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

Sport: Level (check):  Varsity  JV  Modified

Date of last health appraisal: Limitations:  Yes  No

**PART B:**

**Note:** “Yes” to any of these questions does not mean automatic disqualification from the athletic activity indicated in PART A above. However, it may require a review and approval by the school physician before the student can report to practice or tryouts.

**HISTORY SINCE LAST HEALTH APPRAISAL**

Allergies (Bee Sting/Medications/Food/Latex, etc.)  Yes  No

Does the student carry and Epi-Pen® for a life threatening allergy:  Yes  No

Asthma  Yes  No

Does the student carry an inhaler?  Yes  No

Concussion/Head Injury/Seizures  Yes  No

Recent injury that requires medical attention or protective equipment?  Yes  No

Recent illness lasting longer than one week (ie. Mono)?  Yes  No

Currently taking medications  Yes  No

Diabetes/Hypoglycemia  Yes  No

Heart/Blood Pressure Problems  Yes  No

Heat Exhaustion or Stroke  Yes  No

Hearing Impairment  Yes  No

Bleeding Tendency/Anemia  Yes  No

Recent Surgery or Hospitalization  Yes  No

Kidney/Liver Disease  Yes  No

Contact Lenses  Yes  No

Is there any medical condition that might be aggravated by playing sports?  Yes  No

**PART C: TO BE COMPLETED BY PARENT OR GUARDIAN**

Describe the condition or situation that caused any question in PART B to be answered “Yes”.

**PART D: PARENT 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.

SIGNATURE: DATE: / /

**PART E: CONCUSSION AWARENESS**

I have read the attached Concussion Fact Sheet. I understand that in the event of any head injury, my child will be immediately removed from play and that the school must receive documentation of medical treatment prior to returning to any sports activities.

SIGNATURE:

You can view the school’s full concussion policy at [www.uscsd.org/](http://www.uscsd.org/) or obtain a copy through the High School main office or health office.

**PLEASE RETURN TO THE SCHOOL HEALTH OFFICE**

**PART F: TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE**

Sports Participation:  Approved  Referred to School Physician

Signed: Date: / /

School Health Office

If referred to the School Physician:  Requalified  Disqualified

Signed: Date: / /

School Physician