

**North Warren Central School**  
**INTERVAL HEALTH HISTORY FOR SPORTS PARTICIPATION**

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.

Student: \_\_\_\_\_

Age: \_\_\_\_\_

Grade (check):  7    8    9    10    11    12

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

***HISTORY SINCE LAST HEALTH APPRAISAL TO BE COMPLETED BY PARENT OR GURADIAN***

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| Allergies (Bee Sting/Medications/Food/Latex, etc.)                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does the student carry an Epi-pen <sup>®</sup> for a life-threatening allergy? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does the student carry an inhaler?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| We must have a Dr's note on file for your child to carry his/her inhaler.      |  |
| Concussion/Head injury/Seizures  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Recent injury that requires medical attention or protective equipment?         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Recent illness lasting longer than one week (ie. Mono)                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Currently taking medications   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes/Hypoglycemia  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart/Blood Pressure Problems  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heat Exhaustion or Stroke  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hearing Impairment   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Tendency/Anemia   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Recent Surgery or Hospitalization  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Kidney/Liver Disease   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Contact Lenses   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is there any medical condition that might be aggravated by playing sports?     | <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".

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**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.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent's Signature