TO BE COMPLETED NO MORE THAN 30 DAYS PRIOR TO THE START OF THE SPORT SEASON

NIAGARA FALLS CITY SCHOOL DISTRICT

HEALTH SERVICES ***- INTERVAL*** HEALTH HISTORY FOR SPORTS PARTICIPATION

New York State Education Law mandates that 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.

PART A: TO BE COMPLETED BY THE STUDENT

Student:_____ Date of Birth:___/___/___

School: _____Grade (check): ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

Sport:_____

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 may require a review and approval by the District Nurse Practitioner or the School Physician 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.

NEW HISTORY SINCE LAST SPORT PHYSICAL OR SPORT SEASON:

If the answer to any of the following questions is "YES, please describe the condition or situation that prompted your answer.

1. Any NEW injuries requiring medical attention? ___Yes ___No **Date**_____

2. Any NEW illness lasting more than five (5) days or requiring medical attention? ..... ___Yes ___No **Date**_____

3. Currently taking any prescription or non- prescription pill medications, Herbs or Vitamins? ..... ___Yes ___No **Date** _____

4. Treated by your health care provider since last sport physical ___Yes ___No **Date**_____

5. Any NEW feeling of faintness, dizziness, fatigue or chest pain after exercise or exertion? ..... ___Yes ___No **Date** _____

6. Any NEW surgical operations or fractures? ___Yes ___No **Date**_____

7. Any treatment in a hospital or emergency room? ___Yes ___No **Date**_____

8. Developed Asthma or any NEW allergies? ___Yes ___No **Date**_____

9. Any ongoing medical conditions? ___Yes ___No **Date**_____

10. Any change in vision, eye problems or new eyewear? ___Yes ___No **Date**_____

11. FEMALES ONLY: Date of last menstrual period._____

Continue on Back

12. **Any NEW head injury or concussion?** **____Yes ____No Date_____**

EXPLAIN ALL YES ANSWERS HERE:

_____

_____

_____

_____

_____

PART C: Parental Permission

Concussion is a mild traumatic brain injury. Concussion occurs when normal brain functioning is disrupted by a blow or jolt to the head, face, neck or elsewhere on the body with an "impulsive" force transmitted to the head . Recovery from concussion will vary. Avoiding re-injury and over-exertion until fully recovered are the cornerstones of proper concussion management.

Any student demonstrating signs, symptoms or behaviors consistent with a concussion while participating in a school sponsored class, extracurricular activity, or interscholastic athletic activity shall be removed from the game or activity and be evaluated as soon as possible by an appropriate health care professional. The District will notify the student's parents or guardians and recommend appropriate monitoring to parents or guardians. The student should not return to school or activity until released by an appropriate health care professional. The District Medical Director will make the final decision on return to activity including regular class, physical education class and after school sports and activities. Any student who continues to have signs or symptoms upon return to activity must be removed from play/activity and re-evaluated by their health care provider.

Potential signs and symptoms: Appears dazed or stunned, is confused about assignment or position, forgets an instruction, Is unsure of game, score, or opponent, Moves clumsily, Answers questions slowly, Loses consciousness (even briefly), Shows mood, behavior, or personality changes, Can't recall events *prior* to hit or fall, Can't recall events *after* hit or fall. Student complains of headache, pressure in head, nausea or vomiting, balance problems or dizziness, double vision, blurry vision, sensitivity to light or noise, feeling sluggish, hazy, foggy or groggy, concentration or memory problems, confusion, just not "feeling right" or is "feeling down".

ATTENTION PARENT/GUARDIAN

Your signature below is required for sports participation and indicates that:

* You give permission for District Medical Staff to obtain medical information from your child's health care provider if necessary.
* You have read and understand the information regarding concussion management
* You clearly understand these questions are asked in order to decide if your child can safely participate on an athletic team.
* You give permission for the health office to disclose pertinent health information to the coaches..
* The answers given are correct to the best of your knowledge as of this date and that your child has permission to participate in sports.

Signature of Parent:_____ Date:_____

Signature of Student:_____ Date:_____

PLEASE RETURN TO THE SCHOOL HEALTH OFFICE

PART D: TO BE COMPLETED BY SCHOOL PERSONNEL

Date of last sports physical: ____/____/____ Limitations: ☐ Yes ☐ No

Student is currently disqualified for medical reasons: ___Yes ___No

Sports Participation:

____Approved ___Referred to Nurse Practitioner or School Physician

Signed:_____ Date___/___/___

School Nurse

If referred to the Nurse Practitioner or School Physician: ____Re-qualified ___Disqualified

Signed:_____ Date___/___/___

Nurse Practitioner

_____ Date___/___/___

School Physician