Niagara Falls City School District
Health Services – SPORT HEALTH HISTORY

Name_____ Sex____ Age_____ DOB_____ School _____Grade_____

Address_____Phone_____ Sports_____

Health Care Provider_____Phone_____

In case of emergency, contact
Name_____ Relationship_____ Phone (H)_____(W)_____

ALL "YES" ANSWERS MUST BE EXPLAINED IN SPACE PROVIDED. FAILURE TO GIVE EXPLANATION MAY RESULT IN DELAY OF SPORT CLEARANCE FOR YOUR CHILD.

1. Has your Health Care Provider ever denied or restricted your participation in sports for any reason? Yes___ No___
2. Have you had an illness, injury or been to the emergency room since your last check up or sport physical? Yes___ No___
3. Do you have an ongoing or chronic illness? Yes___ No___
4. Have you ever been hospitalized overnight? Yes___ No___
5. Have you ever had surgery? Yes___ No___
6. Are you currently taking any prescription or non - prescription medications? Yes___ No___
7. Have you ever taken any supplements or vitamins to help you gain or lose weight? Yes___ No___
    a. To help you improve your performance? Yes___ No___
8. Have you ever passed out during or after exercise? Yes___ No___
9. Have you ever been dizzy during or after exercise? Yes___ No___
10. Have you ever had discomfort, pain or pressure in your chest during exercise? Yes___ No___
11. Do you have excessive or unexplained fatigue associated with exercise? Yes___ No___
12. Have you ever had racing of your heart or skipped beats? Yes___ No___
13. Has your health care provider ever told you that you have;
    a. High blood pressure Yes___ No___
    b. High cholesterol Yes___ No___
    c. A heart murmur Yes___ No___
    d. A heart infection Yes___ No___
14. Has your health care provider ever ordered a test for your heart? (ECG or Echocardiogram) Yes___ No___
15. Has one or more relatives died of heart problems or of sudden death before age 50? Yes___ No___
    a. Relationship_____
16. Do you have a close relative under age 50 with disability from heart disease? Yes___ No___
    a. Relationship_____
17. Does anyone in your family have a heart murmur, heart problem, or Marfans Syndrome? Circle one and explain.
    a. _____
18. Have you had a severe viral infection, (for example, myocarditis or mononucleosis) in the last month? Yes___ No___
19. Have you ever had a rash or hives develop during or after exercise? Yes___ No___
20. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss gym, a practice or a game? Yes___ No___
21. Have you broken or fractured any bones or dislocated any joints? Yes___ No___
22. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation Physical therapy, a brace, a cast, or crutches? Yes___ No___
23. Have you been told that you have, or have you had an x-ray for, atlantoaxial (neck) instability? Yes___ No___
24. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position***?***
    a. For example, knee brace, special neck roll, foot orthotics, teeth retainer, hearing aid? Yes___ No___
25. Have you ever had a seizure? Yes___ No___
26. Do you have frequent or severe headaches? Yes___ No___
27. Have you ever had numbness or tingling in your arms, hands, legs or feet? Yes___ No___
28. Have you ever had a stinger, burner or pinched nerve? Yes___ No___
29. Have you ever become ill from exercising in the heat? Yes___ No___
30. Have you ever been diagnosed with sickle cell trait? Yes___ No___
31. Do you have any current skin problems? For example itching, rashes, acne, warts, fungus or blisters. Yes___ No___
32. Do you have any allergies (for example, to pollen, medicine, food or stinging insects)? Yes___ No___

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33. Do you have seasonal allergies that require medical treatment? Yes___ No___
34. Do you cough, wheeze, or have trouble breathing during or after exercise? Yes___ No___
35. Do you have asthma? Yes___ No___
36. Have you had any problems with your eyes or vision? Yes___ No___
37. Do you wear glasses, contacts or protective eyewear? Yes___ No___
38. Do you want to weigh more or less than you do now? Yes___ No___
39. Do you feel stressed out? Yes___ No___
40. FEMALES ONLY:
    a. When was your first menstrual period? _____(Date)
    b. How many periods have you had in the last year?_____
    c. What was the longest time between periods last year?_____
    d. Last Menstrual Period _____

41. HAVE YOU EVER HAD A CONCUSSION OR HEAD INJURY? Yes___ No___
42. HAVE YOU EVER BEEN KNOCKED OUT, BECOME UNCONSCIOUS OR LOST MEMORY? Yes___ No___

Concussion is a mild traumatic brain injury. Concussion occurs when normal brain functioning is disrupted by a blow or jolt 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".

PLEASE EXPLAIN ALL "YES" ANSWERS HERE: _____

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PARENTS PLEASE READ COMPLETELY SIGN AND DATE:

I hereby state that to the best of my knowledge, my answers to the above questions are complete and correct.

I have read and understand the information regarding concussion management.

I give permission for the Niagara Falls School District Health Services Staff to obtain medical information concerning my child from his/her health care provider.

Signature of Parent/guardian_____ Date_____

Signature of Athlete_____ Date_____

FOR OFFICIAL USE ONLY:
Matches Cumulative Health Record Yes___ N o____ Initials of School Nurse_____
Note Discrepencies here:_____