Dear Parent/Guardian

The more people who participant interacts with, the closer the physical interaction, the more sharing of equipment there is by multiple players, and the longer the interaction is, the higher the risk of COVID-19 spreading.

Therefore, risk of COVID-19 spread can be different, depending on the type of activity.

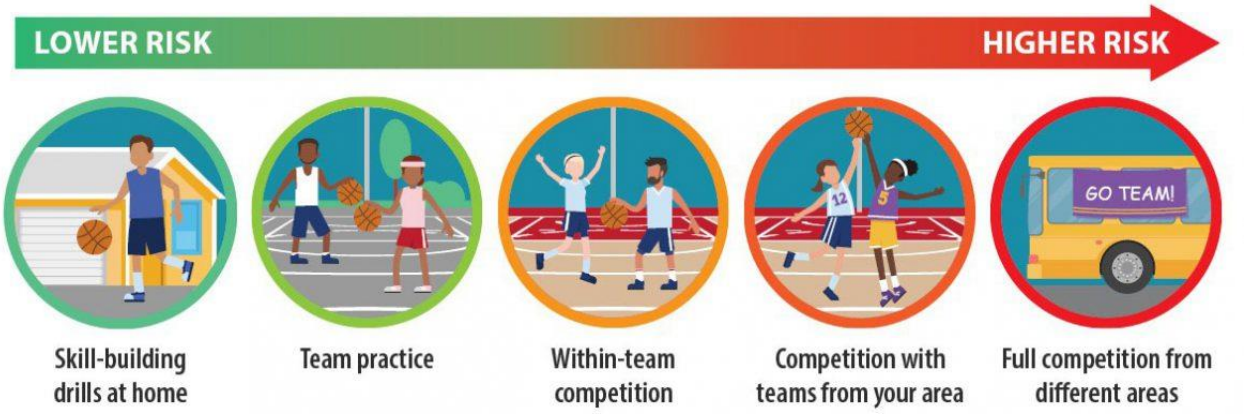
Lowest Risk: Performing skill-building drills or conditioning at home, alone or with members of the same household

Increasing Risk: Team-based practice

More Risk: Within-team competition

Higher Risk: Full competition between teams from the same local geographic area (e.g., city or county)

Highest Risk: Full competition between teams from different geographic areas (e.g., outside county or state)



I understand that playing sports even outdoors can increase the risk of COVID-19. As the parent/guardian of _____ I understand that participating in sports can put my child at greater risk for COVID-19.

Parent/Guardian Signature _____ Date _____

Athlete's Signature _____ Date _____

NIAGARA FALLS CITY SCHOOL DISTRICT

Athletic and Health Service

Student Name:	DOB:
School Name:	Age:
Grade (check): ☐7 ☐8 ☐9 ☐10 ☐11 ☐12	Level (check): ☐ Modified ☐ JV ☐ Varsity
Sport:	Limitations: ☐ Yes ☐ No
Date of last health exam:	Date form completed:

Health History to Be Completed by Parent/Guardian, Provide Details to Any Yes Answers on Back. Medication needed at practice and/or athletic event require the proper paperwork, contact school with questions.

MUST BE COMPLETED IN INK

Has/Does your Child:

General Health Concerns

1. Ever been restricted by a health care provider from sports participation of any reason?
   No ____ Yes ____ Date _____
   Reason _____
2. Have an ongoing medical condition?
   ☐Asthma ☐ Diabetes
   ☐ Seizure ☐ Sickle Cell Trait or Disease
   ☐ Other _____
3. Ever Had surgery?
   No ____ Yes ____ Date _____
   Type _____
4. Ever spent the night in a hospital?
   No ____ Yes ____ Date _____
   Reason _____
5. Been diagnosed with Mononucleosis within the last month?
   No ____ Yes ____ Date _____
6. Have only one functioning kidney?
   No ____ Yes ____ Date _____
7. Have a bleeding disorder?
   No ____ Yes ____ Date _____
8. Have any problems with his/her hearing or wear hearing aid(s)?
   No ____ Yes ____ Date _____
   Right ear ____ Left ear ____
9. Have any problems with his/her vision or vision in only one eye?
   No ____ Yes ____ Date _____
10. Wears glasses or contacts?
    No ____ Yes ____

Allergies

11. Have a life-threatening allergy?
    ☐ Food ☐ Insect Bite ☐ Latex ☐ Pollen ☐ Medicine
    ☐ Other _____
21. Must Carry an Epinephrine Auto Injector?
    No ____ Yes ____ Expiration Date _____

Breathing (Respiratory) Health

12. Ever complained of getting more tired or short of breath then friends during exercise?
13. Wheeze or cough frequently during or after exercise? No ____ Yes ____
14. Ever been told by a health care provider they have asthma? No ____ Yes ____
15. Use or carry an inhaler or nebulizer?
    No ____ Yes ____ Expiration Date _____

Concussion/Head Injury History

16. Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told they had a concussion?
    No ____ Yes ____ Date _____
17. Ever had a head injury or concussion?
    No ____ Yes ____ Date _____
18. Ever had headaches with exercise?
    No ____ Yes ____ Date _____
19. Ever had an unexplained seizure?
20. Currently receive treatment for seizures or epilepsy? No ____ Yes ____ Date _____
    Treatment: _____

Devices/Accommodations

22. Use a brace, orthotic, or other devices?
    No ____ Yes ____
23. Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)?
    No ____ Yes ____ if yes see school nurse for additional paper work.
24. Wears protective equipment such as goggles, athletic cup, orthopedic braces?
    No ____ Yes ____

Female Only

25. Date she started having her period? Month ____ Year ____
26. Age Period began? _____
27. Have regular periods? Y N
28. Date of last period ___/___

Male Only

29. Have only one testicle? ___
30. Have pain or a bulge or hernia in the groin? _____

PLEASE NOTE: hernia check is a required part of the exam.

Family history

31. Any relative been diagnosed with a heart condition, such as a murmur, developed hypertrophic cardiomyopathy, Marfan Syndrome, Brugada Symdrome, right ventricular cardiomyopathy, long QT or short QT syndrome, or catechlaminergic polymorphic ventricular tachycardia? No ____ Yes ____ Relationship _____

COVID-19 Information

32. Has your child ever tested positive for COVID 19? No ____ Yes ____ Date tested _____
33. If yes, what symptoms did your child experience? _____
34. Did your child see a healthcare provider (HCP) for their COVId-19 Symptoms? No ____ Yes ____
35. Did your child have any cardiac symptoms (new fast or slow heart rate, chest tightness or pain, blood pressure changes, or HCP diagnosed cardiac conditioner)? No ____ Yes ____ if yes please provide cardiac update or see your child's school nurse.
36. Was your child hospitalized for COVID-19? No ____ Yes ____ Date tested _____
    If yes did they have a diagnosis of Multisystem inflammatory syndrome (MISC)? No ____ Yes ____
    If yes, is your child currently under care for MISC? No ____ Yes ____

Heart History

37. Ever passed out during or after exercise? No ____ Yes ____
38. Ever complained of light headedness, dizziness or chest pain, pressure or tightness during or after exercise? No ____ Yes ____
39. Ever complained of fluttering in their chest, skipped beats, or their heart racing, or do they have a pacemaker? No ____ Yes ____
40. Ever have a test by a HCP for his/her heart (EKG, echocardiogram stress test)? No ____ Yes ____
41. Ever been told they have a heart condition or problem by a HCP?

☐ Heart infection ☐ murmur ☐ High B/P ☐ Low B/P ☐ High Cholesterol ☐ Kawasaki Disease
☐ Other _____

Skin History

42. Currently have any rashes, pressure sores, or other skin problems? No ____ Yes ____
43. Have had a herpes or MRSA skin infections? No ____ Yes ____ Date _____

Injury History

49. Ever been diagnosed with a stress fracture? No ____ Yes ____
50. Ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling? No ____ Yes ____
51. Ever had an injury, pain, or swelling of joint that caused him/her to miss practice or a game? No ____ Yes ____
52. Have a bone, muscle, or joint injury that bothers him/her? No ____ Yes _____
53. Have joints become painful, swollen, warm or red with use? No ____ Yes ____

Stomach History

44. Ever become ill while exercising in hot weather? No ____ Yes ____
45. Have a special diet or need to avoid certain foods? No ____ Yes ____
46. Have to worry about his/her weight? No ____ Yes ____
47. Have stomach problems? No ____ Yes ____
48. Ever had an eating disorder? No ____ Yes ____

PARENT PERMISSION Your signature below is required for sports participation and indicates that you give permission:

1. District Medical Staff to obtain medical information from your child's health care provider if necessary.
2. School Health office to disclose pertinent health information to the coaches.
3. To Niagara Falls Memorial Medical Center Health Care team to provide a pre-athletic sports evaluation on your child and that all the above answers are correct to the best of your knowledge.

Signature of Parent/Guardian _____ Date _____

Signature of Athlete _____ Date _____

TO BE COMPLETED BY SCHOOL PERSONNEL ONLY: Date of last SPE __/__/__ Limitations ☐ Yes ☐ No

Student is currently Disqualified for medical reason? ☐ Yes ☐ No Restrictions _____

Sports Participation _____ ☐ Approved ☐ Refereed to Medical Director/Nurse Practitioner

Matches CHR ☐ Yes ☐ No List Discrepancies Noted_____

School Nurse Signature _____ Date _____ D14a/b 2/21