Niagara Falls City School District
PREPARTICIPATION/INTERVAL ATHLETIC HEALTH HISTORY

PART A: To be completed by student

Student Name: _____ DOB: ____/____/_____

Parents phone number _____ Emergency phone number_____

Circle school attending --- NFHS _____ LPS _____ GPS _____ NC _____

Grade (check): ◯7 ◯ 8 ◯9 ◯ 10 ◯ 11 ◯ 12 Sport: _____

PART B: To Be Completed by Parent/Guardian in Pen, signed and dated to be accepted. ***Signature confirms consent for physical exam to be done by the NP.*** Please provide details to any yes answers or other pertinent information on back of this form.

	YES	NO	DATE
Ever been restricted by a doctor or Nurse practitioner from sports participation or gym for any reason?			
Have an ongoing medical condition? Please check below: ◯ Asthma ◯ Diabetes ◯ Seizures ◯ Other ◯ Sickle Cell (SC) ◯ SC Trait			
Ever had surgery?			
Ever spent the night in a hospital other than the ER?			
Have a life threatening allergy? ◯ Medication ◯ Food ◯ Insect Bites ◯ Pollen/Seasonal ◯ Latex ◯ Other			
Carry an Epinephrine auto-injector(Epi-Pen)?			
Ever complained of light headedness or dizziness during or after exercise?			
Ever complained of chest pain, tightness or pressure during or after exercise?			
Ever complained of fluttering in their chest, skipped beats, or their heart racing, or does she/he have a pacemaker?			
Has a health care provider ever ordered a test for his/her heart? (such as an EKG, echocardiogram, stress test)			
Ever been told they have a heart condition or problem? ◯ heart murmur ◯ heart infection ◯ high cholesterol ◯ high or low blood pressure			
Ever become ill while exercising in hot weather?			
Ever complained of getting more tired or short of breath than his/her friends during exercise?			
Wheeze or cough frequently during or after exercise?			
Ever been told by their health care provider they have asthma?			
Use or carry an inhaler or nebulizer?			
On a special diet or have to avoid certain foods?			

	YES	NO	DATE
Have they ever taken vitamins or supplements or worry about their weight?			
Have stomach problems?			
Ever had a hit to the head that caused a headache, dizziness, nausea, or confusion, or been told she/he had a concussion?			
Ever have headaches with exercise?			
Ever had a seizure?			
Currently being treated for a seizure disorder or epilepsy?			
Ever been unable to move his/her arms and legs or had tingling, numbness, or weakness after being hit or falling?			
Ever had an injury, pain, or swelling of joint that caused him/her to gym class or miss practice or a game?			
Has She/he ever broken or fractured any bones or dislocated any joints?			
Use a brace, crutches, cast, orthotic or other device?			
Have any problems with his/her hearing or wear hearing aids?			
Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, kidney shield, protective lenses etc.)			
Have any problems with his/her vision or have vision in only one eye?			
Wears glasses or contacts?			
Ever had a hernia?			
Does she/he have only 1 functioning kidney?			
Does she/he have a bleeding disorder?			
Males only: Hernia check is part of the physical exam			
Does he only have one testicle?			
Females only: Please wear tank top under clothing day of physical.	AGE	# of times	DATE
What age did she have her first menstrual period?			
Date of last menstrual period?			
How many times did she get her period in past year?			

Please continue on back

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Family History	YES	NO	List student maternal/paternal aunt, uncle, cousin, sibling etc.
Has any relative been diagnosed with a heart condition or developed hypertrophic cardiomyopathy, Marfan Syndrome, right ventricular cardiomyopathy, long QT or short QT syndrome, Brugada Syndrome, or catecholaminergic polymorphic ventricular tachycardia?			
Has any relative died suddenly before the age of 50 from unknown or heart related causes?			

ALL "YES" ANSWERS FROM BOTH SIDES OF THE FORM MUST BE Explained HERE:

_____

_____

List all current medications 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 sport physical examination from the District Nurse Practitioner.

Signature of Parent: _____ Date _____

Signature of Student: _____ Date _____

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 Restrictions _____

Sports Participation: _____ ◯ Approved ◯ Referred to Nurse Practitioner/Physician

School Nurse Signature _____ Date___/___/___

If referred to the Nurse Practitioner or School Medical Director: ◯ Re-qualified ◯ Disqualified

Nurse Practitioner Signature _____ Date___/___/___

FOR OFFICIAL USE ONLY:

Matches Cumulative Health Record ◯ **Yes** ◯ **No** **Initials of School Nurse**_____

Note Discrepancies here: _____