# Niagara Falls City School District
## NYSED Interval Health History for Athletics

| | |
|---|---|
| Student Name: | DOB: |
| School Name: | Age: |
| Grade (check): ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 | Limitations: ☐ NO ☐ YES |
| Sport | Date of last Health Exam: |
| Sport Level: ☐ Modified ☐ Fresh ☐ JV ☐ Varsity | Date form completed: |

**MUST be completed in Pen and signed by Parent/Guardian - Give details to any YES answers on page 3.**

### Does or Has Your Child

| General Health | No | Yes |
|---|---|---|
| Ever been restricted by a health care provider from sports participation for any reason? | ☐ | ☐ |
| Ever had surgery? | ☐ | ☐ |
| Ever spent the night in a hospital? | ☐ | ☐ |
| Been diagnosed with mononucleosis within the last 6 months? | ☐ | ☐ |
| Have only one functioning kidney? | ☐ | ☐ |
| Have a bleeding disorder? | ☐ | ☐ |
| Have any problems with hearing or have congenital deafness? | ☐ | ☐ |
| Have any problems with vision or only have vision in one eye? | ☐ | ☐ |
| Have an ongoing medical condition? | ☐ | ☐ |
| If yes, check all that apply:<br>☐ Asthma ☐ Diabetes<br>☐ Seizures ☐ Sickle cell trait or disease<br>☐ Other: | | |
| Have Allergies? | ☐ | ☐ |
| If yes, check all that apply<br>☐ Food ☐ Insect Bite ☐ Latex ☐ Medicine<br>☐ Pollen ☐ Other: | | |
| Ever had anaphylaxis? | ☐ | ☐ |
| Carry an epinephrine auto-injector? | ☐ | ☐ |
| **Brain/Head Injury History** | **No** | **Yes** |
| Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told they had a concussion? | ☐ | ☐ |
| Receive treatment for a seizure disorder or epilepsy? | ☐ | ☐ |
| Ever had headaches with exercise? | ☐ | ☐ |
| Ever had migraines? | ☐ | ☐ |

### Does or Has Your Child

| Breathing | No | Yes |
|---|---|---|
| Ever complained of getting extremely tired or short of breath during exercise? | ☐ | ☐ |
| Use or carry an inhaler or nebulizer? | ☐ | ☐ |
| Wheeze or cough frequently during or after exercise? | ☐ | ☐ |
| Ever been told by a health care provider they have asthma or exercise-induced asthma? | ☐ | ☐ |
| **Devices / Accommodations** | **No** | **Yes** |
| Use a brace, orthotic, or another device? | ☐ | ☐ |
| Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)? | ☐ | ☐ |
| Wear protective eyewear, such as goggles or a face shield? | ☐ | ☐ |
| Wear a hearing aid or cochlear implant? | ☐ | ☐ |
| **Let the coach/school nurse know of any device used. Not required for contact lenses or eyeglasses.** | | |
| **Digestive (GI) Health** | **No** | **Yes** |
| Have stomach or other GI problems? | ☐ | ☐ |
| Ever had an eating disorder? | ☐ | ☐ |
| Have a special diet or need to avoid certain foods? | ☐ | ☐ |
| Are there any concerns about your child's weight? | ☐ | ☐ |
| **Injury History** | **No** | **Yes** |
| Ever been unable to move their arms or legs or had tingling, numbness, or weakness after being hit or falling? | ☐ | ☐ |
| Ever had an injury, pain, or swelling of a joint that caused them to miss practice or a game? | ☐ | ☐ |
| Have a bone, muscle, or joint that bothers them? | ☐ | ☐ |
| Have joints that become painful, swollen, warm, or red with use? | ☐ | ☐ |
| Ever been diagnosed with a stress fracture? | ☐ | ☐ |

| Student Name: | | DOB: | |
|---|---|---|---|

## Does or Has Your Child

### Heart Health

Student Athlete Screening for Dominic Murray Sudden Cardiac Arrest Prevention Act

| Ever complained of: | No | Yes |
|---|---|---|
| Ever had a test by a health care provider for their heart (e.g., EKG, echocardiogram, stress test)? | ☐ | ☐ |
| Lightheadedness, dizziness, during or after exercise? | ☐ | ☐ |
| Chest pain, tightness, or pressure during or after exercise? | ☐ | ☐ |
| Fluttering in the chest, skipped heartbeats, heart racing? | ☐ | ☐ |
| Ever been told by a health care provider they have or had a heart or blood vessel problem? | ☐ | ☐ |

If yes, check all that apply:

☐ Chest Tightness or Pain
☐ High Blood Pressure
☐ High Cholesterol
☐ New fast or slow heart rate
☐ Has implanted cardiac defibrillator (ICD)
☐ Has a pacemaker
☐ Other:
☐ Heart infection
☐ Heart Murmur
☐ Low Blood Pressure
☐ Kawasaki Disease

## Does or Has Your Child

| Females Only | No | Yes |
|---|---|---|
| Have regular periods? | ☐ | ☐ |
| **Males Only** | **No** | **Yes** |
| Have only one testicle? | ☐ | ☐ |
| Have groin pain or a bulge, or a hernia? | ☐ | ☐ |
| **Skin Health** | **No** | **Yes** |
| Currently have any rashes, pressure sores, or other skin problems? | ☐ | ☐ |
| Ever had a herpes or MRSA skin infection? | ☐ | ☐ |
| **COVID-19 Information** | **No** | **Yes** |
| Has your child ever tested positive for COVID-19? | ☐ | ☐ |
| If **NO, STOP.** Go to Family Heart Health History. If **YES,** answer questions below: | | |
| Date of positive COVID test: | | |
| Was your child symptomatic? | ☐ | ☐ |
| Did your child see a health care provider for their COVID-19 symptoms? | ☐ | ☐ |
| Was your child hospitalized for COVID? | ☐ | ☐ |
| Was your child diagnosed with Multisystem Inflammatory Syndrome (MISC)? | ☐ | ☐ |

## Family Heart Health History Continued Screening for Dominic Murray Sudden Cardiac APA

A relative has/had any of the following:

Check all that apply:

☐ Enlarged Heart/ Hypertrophic Cardiomyopathy/ Dilated Cardiomyopathy
☐ Arrhythmogenic Right Ventricular Cardiomyopathy?
☐ Heart rhythm problems, long or short QT interval?
☐ Brugada Syndrome?
☐ Catecholaminergic Ventricular Tachycardia?
☐ Marfan Syndrome (aortic rupture)?
☐ Heart attack at age 50 or younger?
☐ Pacemaker or implanted cardiac defibrillator (ICD)?

A family history of:

☐ Known heart abnormalities or sudden death before age 50?
☐ Structural heart abnormality, repaired or unrepaired?
☐ Unexplained fainting, seizures, drowning, near drowning, or car accident before age 50?

If you answered **NO** to ***all*** questions, **STOP**. Sign and date below. **GO** to page 3 to explain any **YES** question.

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

1. The district Medical Staff to obtain medical information from your child's health care provider **if necessary**.
2. For the school Health office to disclose pertinent health information to the coaches.
3. To the Nurse Practitioner/Medical Director to provide a pre-athletic sports evaluation on your child
4. That all the above answers are correct to the best of your knowledge.

Signature of Parent/Guardian _____ Current Phone # _____ Date _____

Signature of Athlete _____ Date _____

D14a/b 6/22

**FOR SCHOOL NURSES ONLY:**

Matches CHR ☐ Yes ☐ No List Discrepancies in progress note and attach - School Nurse Initials _____ Date _____

| Student Name: | | DOB: | |
|---|---|---|---|

**Any yes answers please explain in this section (dates of any surgeries, procedures, or injuries).**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

**FOR SCHOOL NURSES TO COMPLETE IF USED AS AN INTERVAL HEALTH HISTORY.**

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

STUDENT IS CURRENTLY DISQUALIFIED FOR MEDICAL REASONS: _____ YES _____ NO

Sports Participation: _____ Restrictions: _____

____Approved ___Referred to Nurse Practitioner or School Physician

School Nurse Signature _____ Date___/___/___

If referred to the Nurse Practitioner or School Medical Director:

____Re-qualified ___Disqualified

Nurse Practitioner Signature _____ Date___/___/___

School Medical Director Signature _____ Date___/___/___