| 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 month? |  |  |
| 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:  Asthma  Diabetes  Seizures  Sickle cell trait or disease  Other: | | |
| Have Allergies? |  |  |
| If yes, check all that apply  Food  Insect Bite  Latex  Medicine  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? |  |  |
|  |  |  |
|  |  |  |
| 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? |  |  |
|  |  |  |
| Heart Health | | |
| Ever complained of: | | |
| 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  Heart infection  High Blood Pressure  Heart Murmur  High Cholesterol  Low Blood Pressure  New fast or slow heart rate  Kawasaki Disease  Has implanted cardiac defibrillator (ICD)  Has a pacemaker  Other: | | |
|  | | |
| 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 | | |
| 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 | |
| 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 \_\_\_\_\_\_ Student to fill out health questionnaire and sign on page 3

D14a/b 6/22

**FOR SCHOOL NURSES ONLY:** Matches CHR ☐ Yes ☐ No List Discrepancies in progress note and attach School Nurse Initials \_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_ ***Student to fill out Health Questionnaire Version 4 (PHQ-4)* Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Not at all | Several days Over | Over half the days | Nearly every day |
| **Not being able to stop or control worrying** | 0 | 1 | 2 | 3 |
| **Little interest or pleasure in doing things** | 0 | 1 | 2 | 3 |
| **Feeling down, depressed, or hopeless** | 0 | 1 | 2 | 3 |
| **Feeling nervous, anxious, or on edge** | 0 | 1 | 2 | 3 |

**(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)**

Signature of Athlete \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_



**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\_\_\_/\_\_\_/\_\_\_