| 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\_\_\_/\_\_\_/\_\_\_