

CITY SCHOOL DISTRICT OF ALBANY
BUREAU OF HEALTH AND PHYSICAL EDUCATION
SEASONAL SPORTS INTERVAL HEALTH HISTORY

Last Recorded Physical: _____
New Physical Required: <input type="checkbox"/> YES <input type="checkbox"/> NO

Sport: _____	Level: _____	Grade: _____	House: _____
--------------	--------------	--------------	--------------

SN/T Notations: _____

Parent/Guardian: Every sports season, you must complete this form. Use ink & print, unless a signature is requested.

Student's Name: _____ Sex: Male Female Date of Birth: _____

Address: _____ Zip code: _____ Phone: _____

Parent/Guardian Work Phone(s): _____

Current School: _____ Student ID No.: _____ School Attended Last Year: _____

Participation in athletics is voluntary. It is not a part of the regular physical education program. The parent/guardian assumes financial responsibility if their child sustains an injury while participating in interscholastic sporting events. The District's supplementary insurance only assists in payment of medical expenses not covered by the parent's/guardian's personal health insurance coverage.

1. Parent/Guardian: Please check the activities in which your child may participate:

<input type="checkbox"/> BASEBALL	<input type="checkbox"/> BASKETBALL	<input type="checkbox"/> BOWLING	<input type="checkbox"/> CHEERLEADING	<input type="checkbox"/> CROSS COUNTRY	<input type="checkbox"/> FOOTBALL	<input type="checkbox"/> GOLF
<input type="checkbox"/> SOCCER	<input type="checkbox"/> SOFTBALL	<input type="checkbox"/> SWIMMING	<input type="checkbox"/> TENNIS	<input type="checkbox"/> TRACK	<input type="checkbox"/> VOLLEYBALL	<input type="checkbox"/> WRESTLING

2. Parent/Guardian: Please indicate any activity in which your child may NOT participate: _____

3. Parent/Guardian: Please check any of the conditions listed below that your child has had.

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergies - Environmental | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Knee, Ankle, Wrist, or Elbow Pain / Injury |
| <input type="checkbox"/> Allergies – Food, Medication, or Insects | <input type="checkbox"/> Elevated Blood Pressure | <input type="checkbox"/> Nose Bleeds – Frequent or Severe |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eye Disease or Injury | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Spleen Injury / Enlargement |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fracture or Dislocated Bone | <input type="checkbox"/> Loss of Function in One Kidney |
| <input type="checkbox"/> Back or Neck Pain / Injury | <input type="checkbox"/> Headaches - Frequent | <input type="checkbox"/> One Testicle |
| <input type="checkbox"/> Bladder or Kidney Problem / Injury | <input type="checkbox"/> Head Injury or Concussion | <input type="checkbox"/> Severe Hearing Loss |
| <input type="checkbox"/> Blood or Bleeding Disorder | <input type="checkbox"/> Heart Disease, Murmur or Chest Pain | <input type="checkbox"/> Severe Loss of Vision in One Eye |
| <input type="checkbox"/> Chronic Diarrhea or Constipation | <input type="checkbox"/> Heat Exhaustion or Heat Stroke | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Joint, Ligament, or Muscle Injury | |

4. Please give details regarding any of the above conditions that your child has had: _____

5. Parent/Guardian: Please respond to the following questions:

- | | |
|--|--|
| Is your child currently assigned to the Adaptive Physical Education Program? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Has your child ever fainted during exercise? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Has your child ever been unconscious or lost memory as a result of a head injury? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Has your child recently been ill for more than five consecutive days? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Has your child had any injury/illness that required hospitalization, surgery, x-rays, or emergency care? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Is your child currently under a physician's care for any medical condition? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Is your child currently taking any medications? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Has there ever been a sudden death of a family member under fifty years of age? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Does your child have an orthodontic appliance? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Does your child have capped teeth, bridges, or partial dentures? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Does your child wear contact lenses for sports? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Does your child wear glasses for sports? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Since your child's last physical exam for participation in sports, has s/he had any injuries or illnesses? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Do you have any concerns regarding your child's health that you would like to discuss with a physician? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Does your child urinate frequently? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Has your child experienced sudden weight loss of more than five to ten pounds? | <input type="checkbox"/> YES <input type="checkbox"/> NO |

6. If you answered yes to any of the questions on the front of this form (section #5), please use the space below to provide details including dates. If you answered "yes" to one of the last two questions, the School Nurse/Teacher may check your child's urine for sugar.

If your child may require medication during an athletic event, a medication permission form must be on file in the health office. These forms may be obtained from the School Nurse/Teacher.

Parent/Guardian and Student: Please read the statements below, sign where indicated, and return this form to the School Nurse/Teacher as soon as possible.

- To the best of my knowledge, all information provided in the health history is accurate.
- The above named student may participate in the interscholastic program of his/her school including practice sessions, events, and travel to and from athletic contests.
- I give permission for emergency medical treatment deemed necessary by physicians designated by school authorities.

A physical exam is not required at this time for your child to participate in interscholastic sports.

A physical exam is required at this time for your child to participate in interscholastic sports. We encourage you to have your child examined by his/her private physician. If there has been no change in your child's health, any physical completed within 12 months prior to the first day of practice/tryouts will qualify a student for participation in interscholastic sports. Please have your child's health care provider complete the attached physical form (H.E. 104) and return it to the School Nurse/Teacher. If you do not have a health care provider for your child, s/he may contact the School Nurse/Teacher to schedule an appraisal with the school physician. **YOUR CHILD MAY NOT PARTICIPATE IN INTERSCHOLASTIC SPORTS OR PRACTICE UNTIL THE REQUIRED PHYSICAL AND HISTORY HAVE BEEN REVIEW BY THE SCHOOL NURSE/TEACHER.**

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____
 STUDENT SIGNATURE: _____ DATE: _____

PLEASE RETURN THIS HISTORY TO THE HEALTH OFFICE

TO BE COMPLETED BY SCHOOL HEALTH SERVICES PERSONNEL:

Sports Participation: Approved Student referred to the school physician Student referred to private physician

Blood Pressure: _____ Clinitest: _____
.....

TO BE COMPLETED BY THE SCHOOL PHYSICIAN:

This section will be completed only if there is information on the "Sports Interval Health History" or private physical that must be reviewed by the school physician.

Approved for participation Disqualified

Reason for disqualification: _____
Physician's Signature: _____ Date: _____

This certificate is void if the student has sustained a significant injury or has been absent from school for five or more days due to illness or injury. In that event, a new certificate must be issued before s/he may return to interscholastic competition or practice.

Note: The City School District of Albany does NOT permit the use of this information for any purpose other than participation in school related activities.