

Hartford CSD Interval Health History for Athletics – Three Page Form  
**Pages 1& 2 MUST be completed; Page 3 for additional information.**

Student Name:				DOB:			
School Name: Hartford Central School District				Age:			
Grade (check):		7	8	9	10	11	12
Level (check):		Modified		JV		Varsity	
Sport:				Limitations: Yes No			
Date of last health exam:				Date form completed:			

**Health History to Be Completed by Parent/Guardian, Provide Details to Any Yes Answers (attach pages).**

Medicines needed at practice and/or athletic event require the proper paperwork, contact school nurse with questions.

Has/Does your child:		
General Health Concerns	No	Yes
1. Ever been restricted by a health care provider from sports participation for any reason? Explain:	<input type="checkbox"/>	<input type="checkbox"/>
2. Have an ongoing medical condition? <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Seizures <input type="checkbox"/> Sickle Cell trait or disease <input type="checkbox"/> Other (list): _____		
3. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>
5. Been diagnosed with Mononucleosis within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have only one functioning kidney?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have a bleeding disorder?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have any problems with his/her hearing or wears hearing aid(s)?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have any problems with his/her vision or has vision in only one eye?	<input type="checkbox"/>	<input type="checkbox"/>
10. Wear glasses or contacts?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Allergies</b>		
11. Have a life-threatening allergy requiring EpiPen? Check any that apply: <input type="checkbox"/> Food <input type="checkbox"/> Insect Sting <input type="checkbox"/> Latex <input type="checkbox"/> Medicine <input type="checkbox"/> Pollen <input type="checkbox"/> Other: _____		
12. Self-carry an epinephrine auto-injector?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Breathing (Respiratory) Health</b>	No	Yes
13. Ever complained of getting more tired or short of breath than his/ her friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
14. Wheeze or cough frequently during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
15. Ever been told by a health care provider they have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
16. Use or self-carry an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>

Has/Does your child:		
Concussion/ Head Injury History	No	Yes
17. Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told he/she had a concussion?	<input type="checkbox"/>	<input type="checkbox"/>
18. Ever had a head injury or concussion? List Date/ Year:	<input type="checkbox"/>	<input type="checkbox"/>
19. Ever had headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
20. Ever had any unexplained seizures?	<input type="checkbox"/>	<input type="checkbox"/>
21. Currently receive treatment for a seizure disorder or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Devices/Accommodations</b>	No	Yes
22. Use a brace, orthotic, or other device?	<input type="checkbox"/>	<input type="checkbox"/>
23. Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)? If yes, there may be need for another required form to be filled out.	<input type="checkbox"/>	<input type="checkbox"/>
24. Wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Family History</b>	No	Yes
25. Have any relative who's been diagnosed with a heart condition, such as a murmur, developed hypertrophic cardiomyopathy, Marfan Syndrome, Brugada Syndrome, right ventricular cardiomyopathy, long QT or short QT syndrome, or catecholaminergic polymorphic ventricular tachycardia?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Females Only</b>	No	Yes
26. Begun having her period?	<input type="checkbox"/>	<input type="checkbox"/>
27. Age periods began:		
28. Have regular periods?	<input type="checkbox"/>	<input type="checkbox"/>
29. Date of last menstrual period:		
<b>Males Only</b>	No	Yes
30. Have only one testicle?	<input type="checkbox"/>	<input type="checkbox"/>
31. Have groin pain or a bulge or hernia in the groin?	<input type="checkbox"/>	<input type="checkbox"/>

# Hartford CSD Interval Health History for Athletics – P a g e 2

Student Name: \_\_\_\_\_

School Name: Hartford Central School District

DOB: \_\_\_\_\_

Has/Does your child:		
Heart Health	No	Yes
32. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
33. Ever complained of light headedness or dizziness during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
34. Ever complained of chest pain, tightness or pressure during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
35. Ever complained of fluttering in their chest, skipped beats, or their heart racing, or does he/she have a pacemaker?	<input type="checkbox"/>	<input type="checkbox"/>
36. Ever had a test by a health care provider for his/her heart (e.g. EKG, echocardiogram stress test)?	<input type="checkbox"/>	<input type="checkbox"/>
37. Ever been told they have a heart condition or problem by a health care provider? If so, check all that apply: <input type="checkbox"/> Heart infection <input type="checkbox"/> Heart Murmur <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Kawasaki Disease <input type="checkbox"/> Other: _____		
Injury History	No	Yes
38. Ever been diagnosed with a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>

Has/Does your child:		
Injury History continued	No	Yes
39. Ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
40. Ever had an injury, pain, or swelling of joint that caused him/her to miss practice or a game?	<input type="checkbox"/>	<input type="checkbox"/>
41. Have a bone, muscle, or joint injury that bothers him/her?	<input type="checkbox"/>	<input type="checkbox"/>
42. Have joints become painful, swollen, warm, or red with use?	<input type="checkbox"/>	<input type="checkbox"/>
Skin Health	No	Yes
43. Currently have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
44. Have had a herpes or MRSA skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Health	No	Yes
45. Ever become ill while exercising in hot weather?	<input type="checkbox"/>	<input type="checkbox"/>
46. Have a special diet or need to avoid certain foods?	<input type="checkbox"/>	<input type="checkbox"/>
47. Have to worry about his/her weight	<input type="checkbox"/>	<input type="checkbox"/>
48. Have stomach problems?	<input type="checkbox"/>	<input type="checkbox"/>
49. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>

COVID-19 Information	No	Yes
50. Has your child ever tested positive for COVID-19? Date: _____	<input type="checkbox"/>	<input type="checkbox"/>
51. Was your child symptomatic?	<input type="checkbox"/>	<input type="checkbox"/>
52. Did your child see a healthcare provider (HCP) for their COVID-19 symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
53. Did your child have any cardiac symptoms (new fast or slow heart rate, chest tightness or pain, blood pressure changes, or HCP diagnosed cardiac condition)? If yes, please provide additional information.	<input type="checkbox"/>	<input type="checkbox"/>
54. Was your child hospitalized? If yes, provide date(s)?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, was your child diagnosed with Multisystem Inflammatory syndrome (MISC)?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, is your child under a HCP's care for this?	<input type="checkbox"/>	<input type="checkbox"/>

**Please explain fully ANY question you answered yes to on the attached page, include dates if known. Use additional pages if necessary.**

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

School Nurse Review: \_\_\_\_\_ Last Physical Exam Date: \_\_\_\_\_

Medical Director Review: \_\_\_\_\_ Approved ☐ Additional Clearance Needed ☐

