

**PLAINEDGE PUBLIC SCHOOLS
HEALTH HISTORY FOR INTERSCHOLASTIC ATHLETICS**

Student Name _____ Grade _____

Dear Parent or Guardian:

Your son/daughter has elected to participate in interscholastic athletics. To be sure your son/daughter has your permission, and in order to make a proper medical evaluation of your child, you must do the following:

FILL OUT THIS FORM COMPLETELY AND RETURN TO THE SCHOOL NURSE NO MORE THAN 30 DAYS PRIOR TO THE START OF THE SPORT SEASON. Thank you for your cooperation.

Please circle the appropriate answer:

- | | | |
|--|-----|----|
| 1. Any feeling of faintness, dizziness or fatigue after heavy exertion? | Yes | No |
| 2. Any fractures, dislocations, severe sprains or chronic diseases? | Yes | No |
| 3. Has student ever been hospitalized? | Yes | No |
| 4. Has student ever had surgery? | Yes | No |
| 5. Does student have any allergies? | Yes | No |
| 6. Does student take any medication now? | Yes | No |
| 7. Has student ever been refused permission to participate in athletics? | Yes | No |
| 8. Does student wear glasses? Contact lenses? | Yes | No |

Please explain any Yes answers to the questions above. (Use back of form if needed.)

Please check if the student has ever had any of the following:

- | | | |
|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> *Concussion |

***Note: Prior to clearance for Plainedge School District activities such as interscholastic athletics and/or at any point during the year, it is the responsibility of the Parent and the student to alert the Plainedge School District of any prior or new concussions.**

Please give date and explanation if you check any of the above. (Use back of form if needed.)

By signing below, the student and parent/guardian acknowledges that they have provided up to date medical information.

Student Signature

Parent or Guardian Signature

Date

Date _____ Nurse's Copy